Home Health Referral Checklist

Patient Name: _____DOB: _____

Referral From: _____

Phone Number: _____ Fax Number: _____

Number of Pages: _____

Referrals ***Must*** Include the Following Documentation:

- ❒ Demographic Sheet/Face Sheet
- ❒ Physician's Orders for Home Health Services
- ❒ History and Physical, Latest Progress Notes, or Discharge Summary
  - ❒ The above containing documentation supporting the patient's homebound status, the skilled need required, and for what purpose.
- ❒ Pertinent Labs
- ❒ Copy of P.O.L.S.T. if they have one
- ❒ Copy of Advance Directive if they have one

Home Health Referral

Patient Name: _____ **DOB:** _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a ***face-to-face encounter*** with this patient on: _____

I am ordering and certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

- ☐ Skilled Nursing – Due To: _____
- ☐ Physical Therapy – Due To: _____
- ☐ Speech Language Pathology – Due To: _____
- ☐ MSW (Requires primary Service Order) – Due To: _____

Homebound Status:

- ☐ Needs Supportive Device
- ☐ Needs Special Transportation
- ☐ Needs Assistance of Another to Leave Home

OR:

- ☐ Medically Contraindicated
  Time Frame: _____

AND:

- ☐ Inability to Leave Home
  Due To: _____

AND:

- ☐ Leaving Home is a Considerable and Taxing Effort
  Due To: _____

Provider Signature: _____ **Date of Signature:** _____

Provider Printed Name: _____