NCH north country healthcare | North Country Home Health & Hospice Agency

HOME HEALTH REFERRAL FORM

Thank you for referring your patient to NCHHHA.
Please complete and fax this form and all required documentation to: 866-925-8285 Attn: INTAKE.
If you wish to speak with our Intake Department by phone please dial 603-444-8367

CMS may request medical records from Physicians.
Please retain supporting documentation such as D/C summary, labs, and last office visit note and medication profile in your medical record.

PATIENT INFORMATION:

Patient name: _____ DOB: _____ Referral Date: _____
Address: _____ Phone Number: _____
_____
Alternate Contact: _____ Phone Number: _____
PCP: _____ Office Contact: _____

ALL ELEMENTS BELOW ARE REQUIRED IN ORDER TO PROCESS THIS REFERRAL WITHIN 48 HOURS.

DIAGNOSIS / MEDICAL CONDITION: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

_____

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave the home.* _____

ORDERS/ SKILLED SERVICES: *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

_____

☐ Skilled Nursing for: _____ ☐ Occupational Therapy for: _____
☐ Physical Therapy for: _____ ☐ Social Work for: _____
☐ Speech Therapy for: _____ ☐ Home Health Aide for: _____

ADDITIONAL ORDERS: _____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date _____ | _____ | _____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Primary Care Physician (Printed Name) following patient in the community _____

Physician's Printed Name: _____

Physician Signature: _____ Signature Date: _____

Medicare Requires Signature by an MD/DO (PA AND APRN MAY SIGN DURING COVID-19 EMERGENCY)