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: **1-866-925-8285 Attn: Intake.**
If you wish to speak with Intake by phone please dial 603-444-5317

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: ____________________________
☐ Physical Therapy for: ___________________________ ☐ Social Work: ____________________________________
☐ Speech Therapy for: ____________________________ ☐ Home Health Aide: _______________________________

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 final rule allows for APRN and PA to sign without co-signature

NOTICE OF CONFIDENTIALITY: This transmission is intended for the use of the Addressee only and may contain confidential information. If you are not the intended recipient you are hereby notified that any dissemination, distraction, or copying of the information contained in this facsimile is unauthorized and prohibited If you have receive this information in error, please notify the Sender immediately by telephone at **603-444-5317**.