EZ REFERRAL

FACE TO FACE Encounter Date:____________

Date Referred:________________ Start of Care:__________________

To: **INTAKE (Fax) 434-572-6211** From:_____________________________ Office:__________________

Phone:____________________________ Fax:____________________

□ **Demographic sheet attached in lieu of below**

Patient Name: ______________________________ **DOB**:____________ **SSN**:_____________________ **Sex:**□ **M** □ **F**
Phone:__________________ Address:____ NOK: ___________________
Primary Insurance: ______________________ ID#:___________________________

Referring NP/PA/Physician: _____________________________**(PRINT)** **Phone:** __________________________
MD signing HH orders: _________________________________**(PRINT)** **Phone:**_____________________________
** Face to Face Encounter documentation ***MUST BE*** attached/included: DC Summary, Office Note, Consultation- **identify needs for Home Health**

Primary Diagnosis:________________________________ **Secondary Diagnosis:**______________________________

REFERRAL ORDERS

Disciplines and orders: EVAL/TX ☐
□ SN:

□ PT:

□ ST:

□ OT, if indicated □ Home Aide

□ Other Specifics:

____
Next MD Follow-Up Appointment Date/Time:

FACE TO FACE ENCOUNTER N/A ☐

Clinical Findings/Reasons Skilled Service is needed to treat Patient's Illness/Condition:

Clinical Findings/Support for Homebound Status:
___ Non-ambulatory/Confined to Bed or Chair
___ Requires Assistive Device and/or Support of Another Person for Safe Ambulation
___ Cognitive/Psychological Impairment Dependency on Another Person due to DX:_______________________________
___ Limited Endurance due to DX:______________________________
Explain/Measure:_____________________________________
___ Dyspnea on Minimal Exertion-Explain/Measure:_______________
____
___ Physician Ordered Restriction due to:_______________________
____

Physician Printed Name: ____

Physician Signature/Date: ____

Contact Person: ______________________________________ **Phone/Ext:**_____________________

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