



**PLEASE FAX THIS REFERRAL TO 281-554-6748**

PATIENT INFORMATION	PATIENT INSURANCE INFORMATION
Name: _____	Medicare #: _____
Address: _____	Primary: _____
City: _____	Primary Policy #: _____
State: _____ Zip: _____	Secondary: _____
Phone #: _____	Secondary Policy #: _____

ORDERS	
<input type="checkbox"/> Skilled Nurse to evaluate for home care needs	Lab Orders: _____
<input type="checkbox"/> Physical therapy evaluation and treatment	_____
<input type="checkbox"/> Occupational therapy evaluation and treatment	Wound Care Orders: _____
<input type="checkbox"/> Speech therapy evaluation and treatment	_____
<input type="checkbox"/> Medical Social Worker evaluate for community resources	Other: _____

"FACE TO FACE ENCOUNTER" DOCUMENTATION	
Primary Diagnosis & Reason for Home Health Care Referral: _____	
Clinical Findings to Support the Need for Services: _____	
Evidence that Patient is Homebound:(i.e. needs assistance for all activities, residual weakness, requires max assistance/taxing effort to leave home, confusion/unsafe to go out of home alone, severe SOB/SOB upon exertion, unable to safely leave home unassisted and/or any other clinical factors that affect homebound status): _____	
Previous Medical History: _____	
Diabetic Y/N: _____	Most recent medications list included Y/N: _____
Allergies: _____	
"Face to Face" Encounter (Last MD appt. M/D/Y): _____	
The following services are medically necessary for home health care: <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Therapy	
Comments: _____	
Physician Signature: _____ Physician Phone #: _____ Date: _____	

**CONFIDENTIAL:** The medical information in this FAX message is confidential and protected by both State and Federal law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended FAX recipient or the intended recipient's agent, you are hereby notified that you have received this FAX message in error and that review or further disclosure of the information contained in this FAX is strictly prohibited. If you receive this FAX in error, please notify us immediately at the telephone number indicated above and either destroy these documents or return the original to us by mail.

**Village Home Health currently accepts Medicare and US Family Health Plan (USFHP).**

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