FROM OUR HOME TO YOURS

Village

HOME HEALTH

PLEASE FAX THIS REFERRAL TO 281-554-6748

PATIENT INFORMATION

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone #: _____

PATIENT INSURANCE INFORMATION

Medicare #: _____

Primary: _____

Primary Policy #: _____

Secondary: _____

Secondary Policy #: _____

ORDERS

- ☐ Skilled Nurse to evaluate for home care needs
- ☐ Physical therapy evaluation and treatment
- ☐ Occupational therapy evaluation and treatment
- ☐ Speech therapy evaluation and treatment
- ☐ Medical Social Worker evaluate for community resources

Lab Orders: _____

Wound Care Orders: _____

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: ☐ Skilled Nursing ☐ Therapy

Comments: _____

Physician Signature: _____ Physician Phone #: _____ Date: _____

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

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