SELF REGIONAL HEALTHCARE

Home Health Services Referral

Phone (864) 725-7632 Fax (864) 725-7638

Demographics

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Male or Female: _____

Social Security Number: _____ Date of Birth: _____

Caregiver: _____ Phone: _____

POA: _____ Phone: _____

Primary Care Physician: _____

Primary Dx: _____

Secondary Dx: _____

Referral Date: _____

Diabetic: ☐ Yes ☐ No (if yes) Hemoglobin A1C and date it was run: _____

Health Insurance

Primary Payer: _____ Primary Payer ID: _____

☐ Medicare ☐ Medicaid ☐ Commercial

Secondary Payer: _____ Secondary Payer ID: _____

☐ Medicare ☐ Medicaid ☐ Commercial

Authorization Request: ☐ Yes ☐ No (if yes) Auth Number: _____

Services Needed

Qualifying Services:

☐ **Skilled Nursing**

☐Disease Process; Assess & Instruct

☐Med Management; Assess & Instruct

☐Wound Care (specify) _____

_____

☐Lab Work (specify)_____

_____

☐Other (specify)_____

_____

☐ **Physical Therapy** ☐ **Occupational Therapy**

☐Gait Training ☐ Balance ☐HEP

☐Strength/Endurance ☐Transfer Training ☐ADLs

☐Adaptive Equipment Training ☐Lymphedema

☐Home Safety ☐LSVT ☐IADLs (OT only)

☐ Cognition (OT only) ☐Fine Motor Control (OT only)

Other (specify) _____

_____

_____

☐ **Speech Therapy**

☐Dysphasia

☐Aphasia

☐Trouble Swallowing

☐Cognition

Other (specify)

_____

_____

Additional Services:

☐ Home Health Aide

☐ Telehealth

☐ CHF

☐ COPD

☐ Blood Pressure

☐ Other (specify) _____

_____

☐Medical Social Work

☐Financial Planning

☐Community Resources

☐Advance Directives

☐Discharge Planning

☐Family/Caregiver Concerns

Face to Face Encounter

Face-to-face encounter date: _____

Face-to-face reason: _____

Homebound Status (What is the Barrier to leaving their home?) ☐ Taxing Effort ☐ Non-weight bearing

☐ Medically Contraindicated to Leave Home ☐ Requires supportive device or assistance to leave the home

Provider's clinical findings to support ordered services: _____

_____

Provider's clinical findings to support homebound status: _____

_____

Provider's Signature: _____ Date: _____

Provider's Name (PRINT): _____

Contact at Provider's Office: _____ Phone: _____

Disclaimer

The Face-to-Face encounter must be 90 days prior or within 30 days of admission to Home Health.