ACL HOME HEALTH

FORM

Fax to 209-205-9523

Physician _____

Office Contact _____

Phone Number _____

Referral Date _____

HOME HEALTH REFERRAL FORM

Patient Name_____ DOB_____ Phone _____

Address_____ City_____ Zip_____

Emergency Contact_____ Phone_____

Insurance ☐ Medicare ☐ Medi-Cal ☐ Other_____ Plan#_____

Please check home health services being ordered:

☐ Skilled Nursing ☐ PT/OT ☐ Speech Therapy ☐ CHF Telehealth Monitoring ☐ HHA ☐ MSW

Required Attachments:

☐ Demographics ☐ Medication List (if available) ☐ H&P (if available)

Additional Order Instructions:

FACE-TO-FACE ENCOUNTER

I certify this patient is under my care and that I, or a nurse practitioner?clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face to face Encounter on:_____/_____/_____. I further certify to the following:

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (list medical conditions):

My clinical findings support the need for (check all that apply)

☐ **Skilled Nursing** ☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy**

These skilled are needed beacuse:

Further, I certify that my clinical findings support that this patient is homebound as evidenced by:

Certifying Physician Name: _____

Certifying Physician Signature: _____ **Date:**_____

Submit