St. Mary's Home Health Services, Inc.

Date of Referral: _____

Physician/Face-to-Face *Referral Form*

Patient Name: _____ **DOB:** _____

Address: _____ **Phone #:** _____

City: _____ **Zip:** _____

Primary Insurance: _____ **Policy #:** _____

Family Contact: _____ **Phone #:** _____

(Select Type of Care Needed Below)

- ☐ Skilled Nursing Evaluation
  - ☐ Wound Care
- ☐ Physical Therapy Evaluation
- ☐ Occupational Therapy Evaluation
- ☐ Speech Therapy
- ☐ Medical Social Worker
- ☐ Home Health Aide (Personal Hygiene)

Required Information:

☐ Current Medication List

☐ I certify that this patient was under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the **physician face-to-face encounter** requirements with the patient on:

_____ / _____ / _____
Month Day Year

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:

Diagnosis: 1. _____ 2. _____

3. _____ 4. _____

Allergies: _____

I certify that my clinical findings support that this patient is home-bound because:

(i.e.: absence from home requires considerable taxing effort, for medical reasons, religious services and infrequent, or short duration)

_____

_____

Physician's Name: _____ **Phone #:**_____ **Fax #:**_____

Physician's Signature: _____ **Date:** _____

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