OAK GARDENS
HEALTH CARE SERVICES

Home Healthcare Referral

Patient Name: ________________________________ Referral Date: _____________

Address: ______________________ City: ________________ State: ____ Zip: ____________

Phone: ____________________________ DOB: ____________________________________

Surgical procedure (if applicable): _____________ Date: _____________________________

Discharged from (facility name): ____________________ Facility Admit Date: _______________

Payer: ☐ Medicare ☐ Insurance _______________ ☐ Other _________________

ID# ______________________________ Policy #: ______________ Group #: ______________

Primary diagnosis: _____________________________________ Date: ____________________

Other diagnoses: ____

Service: ☐ SN _____ x per week for ______ weeks ☐ HHA ____ x per week for ____ weeks

☐ PT _____ x per week for ______ weeks ☐ ST ____ x per week for ____ weeks

☐ OT _____ x per week for ______ weeks ☐ MSW ____ x per week for ____ weeks

Additional Orders:

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DOCUMENTATION OF FACE-TO-FACE ENCOUNTER

Date of Face-to-Face Encounter: I certify that this patient is under my care and that I, or a nurse practitioner or a physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on (enter date that visit occurred): ____

Medical Diagnosis: for which the Face to Face Encounter was conducted. Medical reason home health services were ordered: (Please list Medical Condition and/or ☐ **SEE ATTACHED DOCUMENTS** (i.e. Office Visit Note or Other Supporting Documentation):

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Medical Necessity: I certify that, based on my findings, the following services are medically necessary home health services: (check all that apply): ☐ Intermittent Nursing ☐ Physical Therapy ☐ Speech Therapy

Homebound Status: Further, I certify that my clinical findings support that this patient is homebound (i.e., absences from home require considerable and taxing effort, and are for medical reasons or religious services, and are infrequent or of short duration when for other reasons) because: ____

Because of the conditions listed above, one or more of the following types of assistance to leave home is normally required:

☐ Assistance of another person is required to leave home safely

☐ Supportive Devices are required to safely leave the home such as: ☐ Cane ☐ Walker ☐ W/C/Scooter ☐ Crutches

☐ Special Transportation is required to leave the home such as: ☐ Transport Van ☐ Ambulance

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Physician Signature: ___________________________ **Date of Signature**: _______________________

Physician Printed Name: ____

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