Better Life
HOME HEALTH

HOME HEALTH REFERRAL FORM
FAX: 352.307.2073
PHONE: 352.307.0073

Please fax this referral form along with the following: 1. Applicable Medical History *(i.e. Recent Progress Note, H&P / Discharge Summary);* 2. Current Medication List; 3. Medicare Patient's Only: Completed Medicare Certification ("Face to Face" visit)

Patient Demographics

First Name			**Last Name**	**Middle Initial**
Date of Birth		**Sex**	**Home Phone**	**Mobile Phone**
Home Address	**Street**		**City**	**Zip**
Service Location *(if not home address)*	**Street**		**City**	**Zip**
Caregiver/Emergency Contact				**Phone**

Insurance
☐ **Medicare** _____ **Commercial Insurance** _____
☐ **Other** _____ **ID#** _____

Diagnosis(es)

Please Check All Home Health Services Ordered:

Home Heath Orders

☐ **Skilled Nursing Services for:**
- ☐ Teaching R/T Diagnosis
- ☐ Observation & Assessment
- ☐ Complex Care Plan Management
- ☐ Diabetic Teaching
- ☐ Wound Care *(attach specific orders)*
- ☐ Home Infusion *(attach specific orders)*
- ☐ Other: _____

☐ **Home Health Aide for:**
- ☐ ADL's

☐ **Physical Therapy Services for:**
- ☐ Gait & Balance Training
- ☐ Therapeutic Exercise
- ☐ Transfer Training
- ☐ ADL Training
- ☐ Other: _____

☐ **Medical Social Worker Services for:**
Note: to order MSW, either SN, PT or ST must also be ordered.
- ☐ Alternate Living Arrangements
- ☐ Community Resources
- ☐ Evaluation of Stress & Coping
- ☐ In-Home Assistance
- ☐ Other: _____

☐ **Occupational Therapy Services for:**
- ☐ ADL Training
- ☐ Energy Conservation Training
- ☐ Equipment & Adaptive Devices
- ☐ Therapeutic Exercise
- ☐ Other: _____

☐ **Speech Therapy Services for:**
- ☐ Language Processing
- ☐ Swallow Evaluation
- ☐ Voice Intelligibility
- ☐ Other: _____

Comments/Additional Instructions:

Physician Information

Referring Physician Provider	**Phone**
	Fax
Following Physician Provider	**Phone**
	Fax
Referring Physician Provider Signature	**Date**