SecureCare 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)

Home Heath Orders

Please Check All Home Health Services Ordered:

___**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**