VNA COMMUNITY HEALTHCARE
BESIDE YOU AT EVERY TURN

PATIENT REFERRAL FORM

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ D.O.B.: ___ ___ / ___ ___ / ___ ___ ___ ___

_____ PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

MD NAME (Printed): _____ MD PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___

NAME OF PERSON REFERRING: _____

INSURANCE

Plan #1: _____ Policy No.: _____ (e.g., Medicare)

Plan #2: _____ Policy No.: _____ (e.g., AARP)

EMERGENCY CONTACT
Name:_____Phone:_____

PRIMARY DIAGNOSIS:_____

MEDICALLY NECESSARY HOME HEALTHCARE SERVICES:

□ **Skilled Nursing** □ **Physical Therapy** □ **Home Health Aides**
□ **Occupational Therapy** □ **Speech Therapy** □ **Medical Social Work**

IF PATIENT IS ON MEDICARE:
The F2F encounter date must be within 90 days prior or 30 days after the date of the home care admission and *related to the reason for the home care referral*.

I certify that this patient is under my care and that I or a Nurse Practitioner or Physician's Assistant had a face to face encounter on: Month_____ Day _____ Year _____

IF PATIENT IS ON MEDICARE:

Certification of Home Health Services
Based on the above findings, I certify this patient is confined to the home and needs intermittent skilled nursing, physical, speech or occupational therapy. The patient is under my care, and I have initiated the establishment and will periodically review the plan of care. I will provide the agency additional information to support the patient's homebound status and need for skilled care. Examples of this information could include physician progress notes, history and physical forms, operative reports, discharge summaries, etc.

PHYSICIAN SIGNATURE: _____ DATE: _____

Please return a copy of the office notes from the F2F encounter visit when returning this signed document.

PLEASE CALL TO CONFIRM OUR RECEIPT OF THIS FAX

□ **CHECK BOX IF NEXT DAY VISIT NEEDED**

FAX LINES: 203.458.4388 or 1.866.862.0999 (toll free)

INTAKE LINES: 203.458.4275 or 1.866.862.0888 (toll free)