VIRGINIA
HOME HEALTH CARE

HOME HEALTH Care Referral Form

PLEASE COMPLETE BOTH PAGES

After hours, weekends, and holidays: Please call (540) 735-2908 , leave your name and phone number. The triage nurse will return your call.

Monday-Friday 9am- 5pm
Please fax referral to (540) 735-2912
Please call (540) 735-2911 to confirm fax

Patient Demographics

PATIENT NAME: _____ DOB: ____/____/_____
HOME ADDRESS:_____ CITY:_____ ZIP: _____
PHONE #: _____

Physician address:_____ CITY:_____ ZIP: _____
Date physician last saw the patient: _____
Is the physician willing to follow for home care: **YES** or **NO**
Expected Start of Care Date: _____

CONTACT PERSON: _____
PHONE #: _____ RELATIONSHIP: _____

Please attach the following if need be.

Diagnosis:
_____

Allergies:
_____

❑ INSURANCE INFORMATION:
Primary:
❑ Medicare ! Medicaid
❑ Anthem
❑ Anthem S
❑ UHC
❑ Other
❑ Commercial
Group#: _____ WC#_____
Subscriber:_____Phone:_____
Relationship:_____

Physician Signature: _____ Date signed: _____
Physician's office contact: _____ Number: _____-_____-_____

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OFFICE USE ONLY

Date Received: _____/_____/_____ Time Taken: _____ Person Taking Referral: _____

HOME HEALTH REFERRAL FORM PHYSICIAN CERTIFICATE OF MEDICAL NECESSITY

Face-to-Face Encounter

Patient Name: _____

Encounter Date and Reason for Encounter

I certify that I, or a qualified non-physician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below due to the medical condition also listed below, which relates to the primary reason the patient requires home health services.

Encounter Date: _____ Diagnosis/Reason: _____

Home Health Services

I certify that based on my findings:

a. Home Health Services are medically necessary for this patient (check all that apply):
- □ Skilled Nursing
- □ Physical Therapy
- □ Occupational Therapy
- □ Speech Language Pathology
- □ Home Health Aide

b. This patient is homebound based on the following information:

_____

_____

My clinical findings support the need for the above services because:

_____

_____

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I certify that this patient is under my care, or has been referred to another physician having professional knowledge of the patient's condition. Services ordered above are needed to treat conditions for which a patient was hospitalized and/or seen in the office. The above information is based on my clinical judgment relating to this patient's medical condition.

Certifying Physician Signature: _____ Date of Signature: _____

Physician Printed Name: _____