



**FAX TO (706) 272 – 6661 WITH YOUR COVER SHEET**

**Please call (706) 226 – 2848 if any questions.**

Please provide the following information (or attach copy of demographic sheet/ insurance card)

Demographics	Referral Source
Patient Name: _____	Primary Care MD _____
Date of Birth: _____ <input type="checkbox"/> M <input type="checkbox"/> F	Phone _____
SS# _____	Contact for Referral _____
Address: _____	Phone _____
City: _____, GA ZIP: _____	
Phone(s): _____	
Alternate Contacts/ Phone(s): _____	
Main Reason for Home Health _____	

Insurance
Health Insurance (Provide ID Number)
<input type="checkbox"/> Medicare _____
<input type="checkbox"/> Medicaid _____
<input type="checkbox"/> Other _____

Qualifying Services	Specific Orders (or attach)
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Assess medications and provide instruction/ education
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Assess disease process and provide instruction/ education
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Lab (specify) _____
<b>Additional Services</b>	<input type="checkbox"/> Wound Care (specify) _____
<input type="checkbox"/> Occupational Therapy	_____
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Evaluate for _____ Therapy.
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Other _____

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*Face to face encounter:** For all Medicare and most Medicare Advantage patients, the patient must have had an encounter with a Physician or non-physician practitioner (Nurse Practitioner or Physician's Assistant) for the reason that the patient needs home health services. This face to face encounter must occur within 90 days prior to or 30 days after the start of home health care.

In order to accept a patient for home health services, Hamilton Home Health requires that documentation of the encounter is provided at referral OR the patient has a visit scheduled with the physician who will be signing home health orders within the next 7-10 days.

**Documentation must provide clinical findings that support SKILLED NEED** (i.e. presence of wounds, inability to ambulate without assistance, new diagnosis with need for education, urinary catheter, etc)

**Documentation must provide clinical evidence of HOMEBOUND STATUS** (Patient has great difficulty or inability to leave home unassisted or outings are infrequent and consist of MD appointments, trips to church or hair dresser due to: (for example) patient becomes extremely SOB with exertion, must use a walker or cane, has medical restrictions due to recent surgery, dementia, pain, etc)

**Please provide the following documentation**

History and physical  Lab or other diagnostic reports if indicated (if DM, last HgA1C)

Documentation of Face to Face Encounter Visit\* (Last visit note/ Addendum/ Discharge summary) OR Patient has an appointment for a face to face visit on \_\_\_\_\_

**THANK YOU FOR THE OPPORTUNITY TO CARE FOR YOUR PATIENT!**