CORPORE SANO
Home Health & Hospice

Five-Star Quality Rated
Centers for Medicare and Medicaid Services

# Referral/ Verbal Order Form

Patient's Name _____D.O.B. _____

Address _____Phone _____

Insurance _____ SSN _____

Primary Diagnoses for Home Health Referral _____

Additional Diagnoses ☐ CHF ☐ DM ☐ COPD ☐ OA ☐ Pain ☐ Depression ☐ Wounds ☐ Frequent Falls ☐ UTI
☐ Gait Abnormality ☐ Parkinson's ☐ Alzheimer's ☐ CKD ☐ Pneumonia ☐ Dementia
☐ Other_____

## Services Requested

☐NURSING ☐PSYCH NURSING ☐PT ☐OT ☐ SPEECH ☐MSW ☐HHA

☐Hospice Eval/Admission ☐Specific Order/Other_____

*Please send: UPDATED medication list with history & physical, and a visit note if available.*

## Face-to-Face Encounter

I certify that this patient is under my care and that I, Dr. _____ or a nurse practitioner or physician's assistant working with me had a face-to-face encounter that meets the physician face-to-face encounter requirements. The encounter occurred on: _____/_____/_____
The encounter occurred for the following problem(s) or diagnoses: _____

_____

- Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing care, physical therapy, occupational therapy and/or speech therapy. The patient is under my care, and I have initiated the establishment of the plan of care. This patient will be followed and the plan of care will be reviewed. If another community based physician is involved in the patient's care these findings in this face-to-face encounter have been communicated.
- I also have provided the agency additional information to support the patient's homebound status and need for skilled care. (Minimal documentation needed is visit note from the date of the F2F Encounter or one of the following: physician progress notes, discharge summaries, history and physical forms, operative reports, referral orders, etc.)

**Physician Printed Name** _____ **Phone** _____

**Physician Signature** _____ **Date of Signature** ____/____/_____

Agency Staff Signature _____ Date of VO_____/_____/_____

***Please attach patient visit note or progress note from date of Face-to-Face Encounter if available***

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