Angels Care Home Health Agency, Inc

REFERRAL FORM

Patient Name ______________________________________DOB ____________________ SSN_____________________

DIAGNOSIS ____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a NP, or a PA working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on: **Face-To-Face Encounter Date**________________________

Based on my findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care, and I have initiated the establishment of the plan of care for home health services.

SKILLED NURSING SERVICES

- Home Safety Assessment
- Medication Education
- Diabetic Education
- Catheter Care
- Ostomy Care
- Injection Teaching/Administering
- Other: ______________________
- Alzheimer's/Dementia Education
- Disease Process Education
- Cardiac Care
- Pulmonary Care
- Wound Care

  -Type of wound____________________

  -Location: ________________________
- IV Therapy/Enteral Feeding

PHYSICAL THERAPY SERVICES

- General Rehabilitation Evaluation
- Gait Training
- Strength Training
- Fall Prevention
- Balance Training
- Transfer Training
- DME Assessment and Education
- Home Exercise Program
- Cardiac Rehabilitation
- Total Hip/Knee Surgery

OCCUPATIONAL THERAPY SERVICES

SPEECH THERAPY SERVICES________

- General OT Evaluation
- ADL Training
- Range of Motion Training
- Adaptive Devices/Orthotics Training

- General ST Evaluation
- Dysphasia
- Dysphagia
- Other ____________________________

MEDICAL SOCIAL WORKER SERVICES ______________ HOME HEALTH SERVICES __________

- Community Resources
- Social/Behavioral Assessment

- ☐ Activities Of Daily Living
- ☐ Other ___________________________________

Physician Name ____ **NPI Number** _________________________________

Physician Signature _____________________________________ **Date** ____

PLEASE FAX A SIGNED REFERRAL FORM, DOCTORS ORDER with DEMOGRAPHICS, MOST RECENT CLINICAL NOTES, CURRENT MED. LIST and INS. CARD to 559-293-4976 or e-mail to: angelscarehomehealth.inc@gmail.com