PRN Home care, Inc. REFERRAL FORM

Phone: 321-751-6390 Fax: 321-751-6389

Doctor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

Patient Address: _____ Phone: _____

Social Security #: _____ Medicare #: _____

Insurer Name #: _____ Insurance ii: _____

Diagnosis: _____

_____

Nursing:

✓ Skilled Observation/Assessment

___ PT Evaluation/Treatment

___ ST Evaluation/Treatment

Non-Medicare Qualifying Skills:

___ Home Health Aide

___ Social Worker

___ OT Evaluation/Treatment

Specific Orders/instructions: _____

_____

_____

CERTIFICATION OF FACE TO FACE ENCOUNTER FOR HOME CARE SERVICES

I certify that a *qualified face-to-face encounter occurred on _____ with the above-mentioned patient for the following medical condition(s): _____

_____

The following clinical findings support that the patient is homebound and that the patient needs intermittent skilled nursing, physical therapy and/or speech-language pathology: _____

_____

_____

_____ _____ _____

Certifying Physician Signature: Certifying Physician Printed: Date:

The physician must document when the physician or allowed non-physician practitioner (NPP) saw the patient and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within 30 days after the start of care.