QUALIS HOME HEALTH SERVICES, LLC

PATIENT REFERRAL FORM

Patient Information

Patient Name:	**Date of Birth:**
Address:	
Home Telephone #:	**Cell Phone #:**
Emergency Contact:	**Emergency Telephone Number:**
Primary Diagnosis:	

Physician Information

Print Physician Name:	
Telephone Number:	**Fax:**
Name of Person Referring:	

Insurance Information

Plan 1:	Policy Number (e.g. Medicare)
Plan 2:	Policy Number (e.g. AARP)

Home Health Care Orders

Services Required: ☐ **RN** ☐ **PT** ☐ **OT** ☐ **ST** ☐ **HHA** ☐ **MSW**

Frequency/Duration: **1-3 visits per week X 60 days** **Other:**

IF PATIENT IS ON MEDICARE: The face-to-face (F2F) encounter date must be within 90 days prior or 30 days after the date of the home care admission and related to the reason for the home care referral.

I certify that this patient is under my care and that I or a Nurse Practitioner or Physician's Assistant had a face to face encounter on:
Month_____ Day _____ Year _____

IF PATIENT IS ON MEDICARE: Certification of Home Health Services Based on the above findings, I certify this patient is confined to the home and needs intermittent skilled nursing, physical, speech or occupational therapy. The patient is under my care, and I have initiated the establishment and will periodically review the plan of care. I will provide the agency additional information to support the patient's homebound status and need for skilled care. Examples of this information could include physician progress notes, history and physical forms, operative reports, discharge summaries, etc.

Physician Signature: _____ Date: _____

Please return a copy of the office notes from the F2F encounter visit when returning this signed document.

PLEASE CALL TO CONFIRM OUR RECEIPT OF THIS FAX
☐ **CHECK BOX IF NEXT DAY VISIT NEEDED**
FAX/INTAKE LINE: (703) 586-9740