Hygia Healthcare, LLC

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REFERRAL FORM/PHYSICIAN ORDER/FACE-TO-FACE

From: _____

Referred by: _____

Tel: _____ Fax: _____

Date: _____

Fax Included:
- ☐ Face Sheet
- ☐ Demographics
- ☐ H& P
- ☐ Physicians Order
- ☐ DC Summery
- ☐ Rx List
- ☐ Face-to-face encounter
- ☐ Others: _____

Patient Information:

Name: _____ SSN: _____ Gender: F ☐ M☐

Tel: _____ Alternate #: _____ DOB: __/__/____ Ht.:_____ Wt: _____

Address: _____

Insurance Information:

☐Medicare#: _____ ☐Others: _____

Diagnosis: _____

My clinical finding support this patient is homebound and meets the needs for below services because:

☐See attached Physician notes ☐Detail explanation: _____

_____

_____

HOME HEALTH ORDERS	SPECIALTY PROGRAM	
☐Skilled Nursing	☐Cardiovascular Care	☐Orthopedic Care
☐Physical Therapy	☐CHF care (LVAD, IV Inotropes)	☐Ostomy/Urological Care
☐Occupational Therapy	☐Diabetic care	☐Post Surgical Care
☐Speech Therapy	☐Infusion Therapy	☐Respiratory (COPD, PNA, Vent)
☐MSW	☐Medication Management	☐Strength/Balance Program
☐Home Health Aid	☐Neurological care (Stroke, MS)	☐Transplant care
☐Others: _____	☐Oncology care	☐Wound Care

DME: □ Oxygen: LPM____ 02sat____% □ 3:1 BSC □ Hospital Bed □ Walker_____ ☐Wheelchair

☐Others: _____

Detailed Orders: _____

_____

_____

_____

I certify that the patient is under my care and that I, or the nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on **(insert date that visit occurred)**: _____ . I certify that, based on my findings, the above services are medically necessary for home health services.

Physician Signature: _____ Date: _____

Physician Printed Name: _____