**HOME HEALTH CARE FAX REFERRAL FORM**

**FAX ALL REFERRALS TO 1-972-408-0891**

PHONE: 972-938-8500
206 YMCA DR. SUITE 105
WAXAHACHIE, TX 75265

Infinite Care Home Health
"Serving Seniors is Our Passion"

**PATIENT INFORMATION**

Name:_____
Address:_____
City:_____
Phone#:_____
DOB:_____Race:_____
SSN:_____Medicaid#:_____

**Emergency Contact**

Name:_____Phone#:_____
Name:_____Phone#:_____

**Insurance:**

_____Medicare ___Medicaid ___Private Insurance
Primary:_____ID#:_____
Secondary:_____ID#:_____

Last Physician Appt/Encounter Date:_____
PrimaryDiagnosis:_____
Secondary Diagnosis:_____
Diabetic: ___YES ___NO
Allergies:_____
Most recent medications list included: ___YES___NO
Home Health in the Past or Current?_____

**ORDERS(Check all that apply):**

___Skilled Nurse to Evaluate for Home Health Needs
___Physical Therapy Evaluation & Treatment
___Occupational Therapy Evaluation & Treatment
___Speech Therapy Evaluation & Treatment
___Medical Social Worker Evaluate for_____
___Home Health Aide

Lab Orders:_____

Wound Care Orders:_____

_____

Other Orders:_____

**"FACE TO FACE ENCOUNTER"** *ALL FIELDS **REQUIRED** FOR ALL MEDICARE PATIENTS: I certify that this patient is under my care and that I, or an nurse practitioner or physician assistant working in collaboration with me or under my supervision, had a face to face visit that meets the physician face to face encounter requirements on the following date. **Date of F2F Encounter:_____**

**Physician that performed F2F Encounter:_____**

**Physician to Certify Home Health Plan of Care:_____**

**Medical Condition: Primary Diagnosis & Reason for Home Health Care Referral:**_____

_____

**Clinical Findings to Support the need for Nursing and/or Therapy Services:**_____

_____

**Statement that Patient is Homebound:**_____

**Referring Physician Name:** _____**Phone#:**_____

**Physician Signature:** _____**Date:**_____

Per 100-02 Ch.7 Sect. 30.5.1.2, for SOC effective 1-1-2015, this documentation is present in the certifying physician's medical record and/or acute/post-acute care facility's medical record. My signature confirms that this documentation will be incorporated into the certifying physician's medical record for the patient and used to support patient's home-bound status and need for skilled care.