altruist HOME HEALTH & HOSPICE

PATIENT REFERRAL & FACE-TO-FACE FORM

Please also remit supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical records; and/or attach your office's demographics / face sheet and/or office visit notes and fax them to: **(214) 594-2192**

PATIENT

Patient Name: _____ SSN: _____

Date of Birth: _____ M F Address: _____

Phone: _____ City, State, Zip: _____

Alternate Contact Name: _____ Last Flu Vaccine Date: _____

Alternate Contact's Number: _____ Contact's Relationship: _____

Insurance Carrier: _____ Medicare or Insurance #: _____
(or Private Pay)

REFERRING PHYSICIAN

Referring Facility: _____ Office Contact Name: _____

Office Contact eMail: _____ Office Contact Phone: _____

Referral Date: _____ Discharge Date: _____ S.O.C Date: _____

Referring Physician: _____ NPI #: _____

Address: _____ City, State, Zip: _____

Physician Phone: _____ Physician Fax: _____ Physician eMail: _____

Primary Physician: _____ NPI #: _____

Address: _____ City, State, Zip: _____

Physician Phone: _____ Physician Fax: _____ Physician eMail: _____

Admit to Home Health: ☐ S/N ☐ P/T ☐ S/T ☐ R/T ☐ O/T ☐ S/W ☐ HHA

DIAGNOSIS / MEDICAL CONDITION: (List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)

_____

_____

_____

I hereby certify that based on my clinical findings, the patient is homebound due to the following reasons:

_____

_____

_____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant 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 requirements with this patient on: (Insert date the face-to-face visit occurred) _____/_____/_____/

Based on the above 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.

Physician's Printed Name: _____

Physician Signature: _____ Date: _____