HOME HEALTH REFERRAL FORM

Phone: 469-779-6406 Fax: 469-333-8002
Email: referrals@BoundlessHomehealth.com

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: __/__/____ Sex: ___ SSN: ___-__-____

Home Address: _____ City: _____ Zip: _____

Phone: ___-___-____ Alt Phone: ___-___-____ Contact Person: _____ Relationship: _____

INSURANCE INFORMATION:

Primary: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ UHC ☐ Aetna ☐ Cigna

Policy #: _____ Group #: _____

Secondary: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ UHC ☐ Aetna ☐ Cigna

Policy #: _____ Group #: _____

Subscriber: _____ Relationship: _____

PHYSICIAN INFORMATION:

Name: _____ NPI: _____

Address: _____

City: _____ Zip: _____

Phone: ___-___-____ Fax: ___-___-____

DIAGNOSIS

1. _____ 3. _____
2. _____ 4. _____

FACE TO FACE ENCOUNTER

I certify that I, or a qualified non-physician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below due to the medical conditions listed above, which relates to the primary reason the patient requires home health services.

Encounter Date: __/__/____ Physician Signature: _____

SKILLED NURSING SERVICES:

☐ Evaluate and Treat ☐ Diabetic Care ☐ Labs ☐ Wound Care ☐ Infusion

THERAPY SERVICES:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Evaluate and Treat ☐ PROM ☐ AAROM ☐ AROM ☐ Stretching

☐ Strengthening ☐ Gait Training ☐ Balance Training ☐ Manual Therapy

☐ Dry Needling ☐ LSVT ☐ Lymphedema Therapy ☐ Wound Care

☐ Precautions: _____

MSW SERVICES:

☐ Evaluation

IV INFUSION:

Drug Name: _____

Dose: _____ Frequency: _____

Route: _____

Start Date: __-__-____ Stop Date: __-__-____

1st Dose: ☐ No ☐ Yes, include anaphylaxis kit

LABS:

☐ CBC with differential ☐ CPK ☐ BMP ☐ CRP ☐ ESR

☐ Lytes: _____ Trough after: 3rd / 4th / _____ dose / __-__-____ date

☐ Other labs: _____

Report labs to: _____

I acknowledge that my entry of [Physician Name] below serves as my electronic approval and signature on this form.

Physician Signature: _____ Date Signed: __/__/____

Physician's Office Contact: _____ Phone: ___-___-____