Home Health Referral

Central Coast
Home Health and Hospice

Phone: (805) 543-2244

FAX: (805) 543-2224

"Patient seen within 24 hours."

START OF CARE ORDERS

Physician: _____

PATIENT INFORMATION

Patient Name: _____

☐ ***FACE SHEET ATTACHED*** *(or complete information below):*

DOB: ___/___/___ ☐ Male ☐ Female

Address: _____ Contact Phone: _____

City: _____ State: ____ Zip: _____

SSN: _____ Allergies: _____

Patient/Contact Person email (if available): _____

INSURANCE INFORMATION

☐ Medicare ☐ Other: _____ ID#: _____

I CERTIFY THAT, BASED ON FINDINGS, THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY *(check all that apply):*

Skilled Nursing
- ☐ Medication Management
- ☐ Pain Management
- ☐ Cardiac Care
- ☐ Diabetic Management
- ☐ Respiratory
- ☐ _____

Physical Therapy
- ☐ Weakness
- ☐ Ambulation/Gait Training
- ☐ Transfers
- ☐ Wheelchair Mobility
- ☐ Fall Risk
- ☐ Range of Motion
- ☐ Parkinson's Wellness Program

Speech Therapy
- ☐ Dysphasia (speech)
- ☐ Dysphagia (swallowing)
- ☐ Impaired Cognition
- ☐ _____

- ☐ **Occupational Therapy**
- ☐ **Registered Dietitian**
- ☐ **Medical Social Worker**

Labs
- ☐ CBC
- ☐ CMP
- ☐ BMP
- ☐ UA
- ☐ PT/INR
- ☐ Other

Other
- ☐ Wound Care
- ☐ Palliative Care Program
- ☐ Lymphedema Therapy

Comments:

☐ ***ATTACHED ARE PROGRESS NOTES TO COMPLETE FACE-TO-FACE REQUIREMENTS:***

DIAGNOSES: _____

HOMEBOUND STATUS: _____

FACE-TO-FACE DATE: ____/____/_____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter with this patient that meets the physicians face-to-face encounter requirements with this patient (must be 90 days prior to or 30 days after start of home health services).

X _____ _____

Physician's Signature/Verbal Orders by **Date**