COVID-19

REFERRAL FORM

START OF CARE ORDERS

Patient seen within 24 hours.

Central Coast
Home Health and Hospice

HOME HEALTH/PALLIATIVE FAX:
(805)543-2224
HOSPICE FAX:
(805)540-6025

Physician: _____

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___ ☐ **Male** ☐ **Female** **Allergies:**_____

Address:_____ **Contact Phone:**_____

City:_____ **State:**_____ **Zip Code:**_____

Please Send Facesheet, Insurance Card, H&P, Recent Progress Notes, DNR/POLST

HOME HEALTH ☐ ***PALLIATIVE*** ☐ ***HOSPICE*** ☐

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

Asymptomatic COVID-19 TEST

☐ Pre-op patient surgery date: _____

Skilled Nursing

☐ Respiratory Care/COVID-19 Edu
☐ Cardiac Care
☐ Diabetic Management
☐ Medication Management
☐ Other _____

Physical Therapy

☐ Respiratory Care/ Postural Drainage

☐ **Confirmed COVID-19(U07.1)**

☐ Acute Bronchitis
☐ Lower Respiratory Infection ☐ URI
☐ Acute Respiratory Distress Syndrome
☐ Pneumonia
☐ Other_____

☐ **Suspected/Possible COVID-19**

☐ Acute Bronchitis
☐ Lower Respiratory Infection
☐ Acute Respiratory Distress Syndrome
☐ Pneumonia
☐ Other_____

Co-morbidities

☐ HTN
☐ CHF
☐ COPD
☐ Diabetes (with complication/ specify type)_____
☐ Other Respiratory Disease_____
☐ Dementia
☐ Alzheimer's Disease
☐ Renal Disease Specify_____
☐ Other _____

Labs: ☐ CBC ☐ CMP ☐ BMP ☐ UA ☐ PT/INR ☐ COVID-19 ☐ Other _____

COMMENTS: _____

_____

DIAGNOSES: _____

FACE-TO-FACE DATE: ___/___/___ **HOMEBOUND: YES** ☐

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**

HOME HEALTH/PALLIATIVE PHONE: (805)543-2244 **HOSPICE PHONE: (805)540-6020**