REFERRAL FORM

Central Coast
Home Health and Hospice

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

START OF CARE ORDERS

Patient seen within 24 hours.

Physician: _____

PATIENT INFORMATION

Patient Name: _____

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

Contact Person (if different from patient) _____ **Contact Phone:** _____

Address: _____ **City:** _____

Zip Code: _____

Please Send Facesheet, 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):

Skilled Nursing	**Physical Therapy**	**Speech Therapy**	**Occupational Therapy**
☐ Medication Management	☐ Ambulation/ Gait Training	☐ Dysphasia (speech)	☐ ADL/IADL Retraining
☐ Pain Management	☐ Fall Risk	☐ Dysphasia (swallowing)	☐ Adaptive Equipment/ DME Training
☐ Cardiac Care	☐ Range of Motion	☐ Impaired Cognition	☐ Low Vision Program
☐ Diabetic Management	☐ Parkinson's Wellness Program	☐ _____	☐ Home Safety
☐ Respiratory	☐ _____		☐ Fine Motor
☐ _____			☐ _____

Labs

☐ CBC ☐ UA
☐ CMP ☐ PT/INR
☐ BMP
☐ _____

Other

☐ Wound Care Location: _____ Type: _____
☐ Lymphedema Therapy
☐ _____
☐ _____

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**