

# EZ REFERRAL



**FACE TO FACE** Encounter Date: \_\_\_\_\_

Date Referred: \_\_\_\_\_ Start of Care: \_\_\_\_\_

To: INTAKE (Fax) 434-384-2811 From: \_\_\_\_\_ Office: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Demographic sheet attached in lieu of below

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Phone: \_\_\_\_\_ Address: \_\_\_\_\_ NOK: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Referring NP/PA/Physician: \_\_\_\_\_ (PRINT) Phone: \_\_\_\_\_

MD signing HH orders: \_\_\_\_\_ (PRINT) Phone: \_\_\_\_\_

\*\* Face to Face Encounter documentation MUST BE attached/included: DC Summary, Office Note, Consultation- identify needs for Home Health

Primary Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

## REFERRAL ORDERS

## FACE TO FACE ENCOUNTER N/A

Disciplines and orders: EVAL/TX

SN:

PT:

ST:

OT, if indicated  Home Aide

Other Specifics:

Next MD Follow-Up Appointment Date/Time: \_\_\_\_\_

Clinical Findings/Reasons Skilled Service is needed to treat Patient's Illness/Condition:

### Clinical Findings/Support for Homebound Status:

\_\_\_ Non-ambulatory/Confined to Bed or Chair

\_\_\_ Requires Assistive Device and/or Support of Another Person for Safe Ambulation

\_\_\_ Cognitive/Psychological Impairment Dependency on Another Person due to DX: \_\_\_\_\_

\_\_\_ Limited Endurance due to DX: \_\_\_\_\_

\_\_\_ Explain/Measure: \_\_\_\_\_

\_\_\_ Dyspnea on Minimal Exertion-Explain/Measure: \_\_\_\_\_

\_\_\_ Physician Ordered Restriction due to: \_\_\_\_\_

Physician Printed Name: \_\_\_\_\_

Physician Signature/Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone/Ext: \_\_\_\_\_

**FIRST DOMINION HOME HEALTH CARE 2808 Old Forest Road, Lynchburg, VA 24501 Rev.03.2016**

**Phone:434-384-2800 Fax:434-384-2811 Email: [fdhhc@firstcare.biz](mailto:fdhhc@firstcare.biz) Web: [fdhhomecare@firstcare.biz](http://fdhhomecare@firstcare.biz)**