Accredited by the
Joint Commission
since 2011

Home Health Services Referral Intake Form

3120 WILLOW AVE, SUITE # 102, CLOVIS, CA 93612 TEL: 559.412.7953 FAX: 559.492.3503 eFAX: 559-513-8126

PATIENT DEMOGRAPHICS

Patient Name: ______________________________ DOB: ________________

Address: ____

Telephone #: ______________________________ SSN: ________________

Pt Representative Name and Tel #: ____

Primary Health Insurance: ____________________ Policy #: _____________

REFERRAL INFORMATION

Ordering Physician: _______________________ Tel #: ________________

Is ordering physician the primary care physician? ❒ YES ❒ NO, pls. complete info below

Primary Care Physician: ____________________ Tel #: ________________

Home Health Order: pls. indicate reason(s)/diagnosis supporting ordered services

❒ Skilled Nursing: ____

❒ Physical Therapy: ____

❒ Occupational Therapy: ____

❒ Speech Therapy: ____

❒ Medical Social Services: ____

❒ Home Health Aide: ____

Homebound Reason: select all that apply

❒ Needs assistance for all activities ❒ Taxing/considerable effort to leave home

❒ Severe SOB or SOB upon exertion ❒ Confusion, unsafe to go out of home alone

❒ Requires the use of AD to ambulate: cane / walker / wheelchair /other: __________________

Estimated length of need: (circle one) __________ days / weeks / months

CMS FACE-TO-FACE ATTESTATION

I certify that this patient is under my care and that I, or a non-physician practitioner working in collaboration with me or under my supervision, had a face-to-face encounter that meets the CMS requirements (90 days prior to the start of care date or within 30 days after the start of care date). This face-to-face encounter for this patient occurred on: ______________ (date)

Physician's Signature: ______________________________ Date: ________________

FOR HEALTHPOINT HHA OFFICE USE ONLY

Referral Received on: _________ by: ______________ MD Pecos-registered: Y / N Pt eligible: Y / N

Verified w/ Ordering MD office: Staff name: ______________ Date: _________ H&P received on: _________

Verified HH order w/ pt on _________: ❒ Agreed, SOC scheduled for: _______________ ❒ Refused HHA services