Home Health Referral Form

Monday-Friday 9am-5pm
*Phone: (786) 558-5148
Fax: (786) 558-5192
Website: *oasishp.net*
**24 hr On-call service available*

Please complete form and fax the following:

- Demographics/Face Sheet
- Discharge Summary or last office visit note
- Medication profile
- Labs

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ____________ SSN: ______________

*Home Address: __________________ Apt. #: ______ City/State: __________ Zip Code: __________

Contact/Caregiver Person: ______________ Phone #: ______________ Relationship: ____________

Patient Phone #: ______________ Height: ____________ Weight: ___________ ☐ Male ☐ Female

Date Physician last saw patient: ______________ Referral Date: __________________

Diagnosis: ______________________________ Allergies: ______________________

Referral Source: ___________________________ *Building Access Code (if applicable): _______

INSURANCE INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Other Commercial *If other, please list:* ______________________

Group #: ___________________________ WC #: ______________________

Subscriber: _________________________ Phone #: ___________________________

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Grandparent ☐ Sibling ☐ Friend

☐ Child ☐ Other: __________________________

Home Care Services Needed: ***(Select all that apply)***

☐ Skilled Nursing
☐ Home Health Aide
☐ Occupational Therapy
☐ Infusion Therapy
First Dose: ☐ Yes ☐ No
☐ Concierge/Private Duty
☐ Physical Therapy
☐ Speech Therapy
☐ Nutrition Services
☐ Wound Care
☐ Respiratory Therapy
☐ Lab Services

For Infusion Services: ***Please identify type of access***

☐ PICC Line (length) ____ ☐ Midline (length) _____
☐ Central Line – Date Placed: ________________
Circle one: (Single/Double/Triple Lumen)

☐ Port: Last accessed __________
☐ Peripheral IV

PHYSICIAN CERTIFICATE OF MEDICAL NECESSITY

I certify that this patient is under my care and that I, or nurse practitioner or physician assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date ______________

Based on my findings, I certify that this patient is confined to the home and needs home health services as indicated above. The patient is under my care, and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: ______________________________________

Physician Signature ______________________ **Signature Date:** ___________

NOTICE: The attached communication contains privileged and confidential information. If you are not the intended recipient, ***DO NOT*** *read, copy, or disseminate this communication. Non-intended recipients are hereby placed on notice that any unauthorized disclosure, duplication, distribution, or taking of any action in reliance on the contents of these materials is prohibited. If you have received this communication in error, please destroy all pages and contact the sender or Oasis Health Partners at 786-558-5148.*