Physician Form

HOMECARE MARYLAND REFERRAL FORM

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and the following information (or attach demographics / face sheet) and office visit note below.

PATIENT INFORMATION

Patient Name: _____ SSN: _____

Date of Birth: _____ ☐ M ☐ F Address: _____

Phone: _____ City, State, Zip: _____

Emergency Contact Name: _____ Last Flu Vaccine Date: _____

Emergency Contact's Number: _____ Referral Date: _____

Primary Care Physician: _____ Insurance Information: _____ *(or attach copy)*

Primary Care Physician Number: _____

Office Contact Name: _____ Office Contact Number: _____

DIAGNOSIS / MEDICAL CONDITION: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

_____

_____

SKILLED SERVICES / INTERVENTIONS: *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

☐ Skilled Nursing for: _____ ☐ Occupational Therapy: _____

☐ Physical Therapy for: _____ ☐ Social Work: _____

☐ Speech Therapy for: _____ ☐ Home Health Aide: _____

ADDITIONAL ORDERS: _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.

CLINICAL FINDINGS: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

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_____

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*

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