



ADORATION
HOME HEALTH

FAX: 615.733.9988
PHONE: 615.733.3600

HOME HEALTH REFERRAL ORDER

To best serve your patient, please include all relevant medical documentation and forms, including, where applicable, those pertaining to HISTORY & PHYSICAL, DISCHARGE SUMMARY, PATIENT DEMOGRAPHICS, AND LAB/X-RAY.

REFERRAL INFORMATION

CALLER: _____ CALLER PHONE NUMBER: _____ REFERRAL TAKEN BY: _____

TODAY'S DATE: ____ / ____ / ____ REQUESTED SOC DATE: ____ / ____ / ____ *If no SOC date noted, care provided within 48 hours.*

PHYSICIAN'S NAME: _____ TELEPHONE: _____

NPI #: _____ OFFICE CONTACT: _____

FACILITY NAME: _____ FACILITY CONTACT: _____

How did you hear about Adoration Home Health?

PATIENT INFORMATION

PATIENT NAME: _____ DOB: ____ / ____ / ____

STREET ADDRESS: _____ APT #: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

ALLERGIES: _____

CAREGIVER/EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP: _____

PHONE: _____

HOME WORK CELL

INSURANCE INFORMATION

PATIENT MEDICARE #: _____

INSURANCE CARRIER: _____

INSURANCE ID: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

PRIMARY DIAGNOSIS: ICD-9: _____ PLEASE DESCRIBE: _____

OTHER RELEVANT DIAGNOSES: _____

HOME HEALTH SERVICES NEEDED

NURSING

PHYSICAL THERAPY

TELEHEALTH

OTHER (DESCRIBE) _____

SW

HHA

OT

SPEECH THERAPY

FACE TO FACE ENCOUNTERS

I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND HAD A FACE TO FACE ENCOUNTER RELATED TO THE PRIMARY REASON FOR HOME HEALTH SERVICES, WITH MYSELF OR NON-PHYSICIAN (NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST/PHYSICIAN ASSISTANT) WITHIN 90 DAYS PRIOR OF THE START OF CARE FOR HOME HEALTH SERVICES.

1. DATE OF FACE TO FACE ENCOUNTER: ____ / ____ / ____

2. MY CLINICAL FINDINGS SUPPORT THE NEED FOR THE ABOVE HOME HEALTH SERVICES BECAUSE:

3. FURTHER, I CERTIFY THAT MY CLINICAL FINDINGS SUPPORT THAT THIS PATIENT IS HOMEBOUND BECAUSE: (EX: LEAVING HOME REQUIRES CONSIDERABLE TAXING EFFORT, AMBULATES WITH USE OF ASSISTIVE DEVICE OR PERSONS, COMPROMISED IMMUNE SYSTEM OR PHYSICAL LIMITATION, EXPERIENCES SHORTNESS OF BREATH WITH EXERTION)

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____ / ____ / ____