ADORATION®
HOME HEALTH

FAX: 662.455.6104
PHONE: 800.287.3256

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 ☐ SW ☐ OT ☐
PHYSICAL THERAPY ☐ HHA ☐ SPEECH THERAPY ☐
TELEHEALTH ☐
OTHER (DESCRIBE) ☐ _____

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**: _____ / _____ / _____