HealthQuest Home Health

Referral Form

Fax: 979-691-5781 Phone: 979-846-7870

Instructions: Please complete this form, sign, date, and return to the home health agency. All fields are required.

Date: _____Patient's Name:_____DOB:_____Gender_____

Address:_____City:_____Zip:_____

Phone:_____Alt Phone: _____Medicare #_____

Emergency Contact Name:_____Phone:_____

Diagnosis:_____

Date of Last Face-to-Face Visit:_____ mm/dd/yyyy

Services Requested: □ Nursing □ PT □ OT □ ST □ AIDE

Special Instructions/Additional Orders:

Statement of Homebound Status: *I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the face-to-face encounter requirements, i.e. a visit within 90 days preceding certification or not later than 30 days following certification. Based on my findings, I certify that the patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. The patient is under my care, and I have initiated the plan of care. This patient will be followed by a physician who will periodically review the plan of care.*

Please provide the Face-to-Face Visit Progress Notes, along with a current Medication Profile with your referral.

Thank you!

Physician Printed Name:X_____

Physician Signature: X_____Date:_____

Form Last Revised 02/12/18