

MR #:

Priority Code: 1 2 3

Admit Date:



Branch _____

Provider # _____

REFERRAL FOR HOME HEALTH SERVICE

DATE: _____ TIME _____ AM / PM

REFERRAL SOURCE: _____

NEW REFERRAL RE-ADMIT

PHYSICIAN: _____ NPI# _____ PHONE #: (____) _____
ADDRESS: _____ CITY: _____, TN ZIP: _____
INDIVIDUAL MAKING REFERRAL: _____ PHONE #: (____) _____ TITLE: _____

PATIENT NAME: _____ PHONE #: (____) _____
ADDRESS: _____ CITY: _____, TN ZIP: _____
SOCIAL SECURITY #: _____ - _____ - _____ BIRTHDATE: ____/____/____ GENDER M F RACE: _____
CONTACT PERSON/RELATIONSHIP: _____ PHONE #: (____) _____

INSURANCE: (COMPLETE PRE-CERTIFICATION ELIGIBILITY FORM)

MEDICARE: YES NO IF YES #: _____ EFFECTIVE DATES: A ____/____/____ B ____/____/____

TENNCARE: <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, Complete Below)	PRIVATE: <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, Complete Below)
GROUP #: _____ ID# _____	GROUP #: _____ ID# _____
GUARANTOR: _____	GUARANTOR: _____
COMPANY _____	COMPANY _____
ADDRESS _____	ADDRESS _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ PRIMARY OR SECONDARY: _____	PHONE: _____ PRIMARY OR SECONDARY: _____
INSURANCE APPROVAL REQUIRED/OBTAINED: <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE APPROVAL REQUIRED/OBTAINED: <input type="checkbox"/> YES <input type="checkbox"/> NO
CONTACT PERSON: _____	CONTACT PERSON: _____

PERTINENT INFORMATION/SPECIFIC ORDERS:

MOST RECENT HOSPITALIZATION/IN-PATIENT STAY: ADMIT DATE: ____/____/____ DISCHARGE DATE: ____/____/____

HOSPITAL/FACILITY NAME: _____ LOCATION: _____

DIAGNOSIS: PRIMARY _____ SECONDARY _____

PREVIOUS HOME HEALTH CARE AGENCY: _____

DATE OF FLU INJ ____/____/____ PNEUMONIA INJ ____/____/____ DATE OF RECENT MD VISIT ____/____/____ HOSP MD OFFICE

SPECIFIC ORDERS: _____

SN _____ WOUND CARE: _____

PT _____

AIDE _____

MSS _____ INFUSION: _____

OT _____

ST _____

REFERRAL TAKEN BY (SIGNATURE/TITLE): _____ DATE: ____/____/____

CO-SIGNATURE/TITLE (IF APPLICABLE): _____ DATE: ____/____/____

FACE TO FACE ENCOUNTER: (to be completed by physician only or see attached documentation)

DATE OF ENCOUNTER: _____ MEDICAL CONDITION FOR ENCOUNTER: _____

SERVICES NEEDED: _____

CLINICAL FINDINGS: _____

HOMEBOUND STATUS: _____

PLEASE REVIEW THE (VERBAL) REFERRAL FOR HOME HEALTH SERVICES RECEIVED ON YOUR PATIENT. INDICATE ANY CHANGES YOU FEEL ARE NECESSARY. PLEASE SIGN, DATE AND RETURN ORDERS WITHIN 48 HOURS. KEEP A COPY FOR YOUR RECORDS. THANK YOU. (DATE AGENCY RECEIVED ORDER: ____/____/____)

PHYSICIAN SIGNATURE: _____ DATE: ____/____/____