Pike County Health Department
Home Health & Hospice

Referral for Home Health Services

FAX BACK TO (573)324-5517 WITH YOUR COVER SHEET
CALL (573)324-2111 TO VERIFY RECEIPT OF INFORMATION

We will open to Home Health services within 48 hours of discharge from your facility, unless otherwise directed.

Please provide the following information or attach a copy of demographic sheet/insurance card.

Demographics (or attach)

Patient Name:
Date of Birth: / / M F SS#
Address:
City: Zip:
Phone(s):
Alternate Contacts/Phone(s):
Main Reason for Home Health:

Referral Source

Primary Care MD:
Phone:
Contact for Referral:
Phone:

Health Insurance/Provide ID Number
(Or attach copy of card)

Medicare
Medicaid
Other

Qualifying Services

Skilled Nursing
Physical Therapy
Speech Therapy

Additional Services

Occupational Therapy
Social Worker
Home Health Aide

Specific Orders (or attach)

Instruct and Assess Medications
Assess and Instruct Disease Process
Lab (specify)
Wound Care (specify)
Evaluate for Therapy
Other

* **Face to Face Encounter:** For all **Medicare patients**, a physician must have had a Face to Face visit with the patient for the reason that the patient needs home health services. This visit must occur within 90 days prior to, or 30 days after the start of home health care. Please complete the information below for all **Medicare** recipients.

Face to Face Visit Date: Reason:

Clinical Findings that Support Home Health Services:
(Findings indicate skilled need, i.e. presence of wounds, inability to ambulate without assistance, recent surgery with pain, urinary catheter, etc.)

Clinical Findings that Support Homebound Status:
(Patient as great difficulty or inability to leave home unassisted or outings are infrequent i.e. patient becomes extremely SOB with exertion, must use a walker and assist of one person to leave home, medical restrictions due to recent surgery, dementia, etc.)

This form was completed by
Primary Care Physician (PCP) from Face to Face Visit
PCP Based on information from acute/post - acute facility physician
PCP based on collaboration with Non-Physician Practitioner

Physician Signature Date
Physician Printed Name

SUBMIT THIS FORM **PRINT THIS FORM**