PO Box 432 - North Conway NH 03860
Phone: (603) 356-7006 ♥ Fax: (603) 356-8134

PATIENT REFERRAL FORM

Please fax demographics and clinicals with this form to (603) 356-8134.
**** Please note, an incomplete referral will slow down pt.'s admission to home care.**** ***Thank you!***

Patient Name: ___________________________________ DOB: _________________ [ ] Male [ ] Female

Information to be faxed with Referral:

[ ] Demographics with Ins. Info. [ ] Recent Progress Notes Pertaining to Face to Face Date [ ] Diagnosis List
[ ] Hosp. H&P (Recent) [ ] Hosp. DCH Summary [ ] Office visit notes from most recent visit [ ] Medication List

PHYSICAL ADDRESS:____

MAILING ADDRESS:____

HOME TELEPHONE:_______________________**CELL:**_______________________**OTHER:**_______________

HEALTH INS ID #: D Medicare (requires Face to Face Encounter form)___________________________

D Other:____

SPECIFIC SERVICES BEING ORDERED:

D Skilled Nursing_______________________________________
D Physical Therapy_______________________________________
D Occupational Therapy___________________________________
D Speech Therapy____
D Hospice____

"Face-to-Face Encounter" (F2F) Documentation:

I, or a nurse practioner, or physician's assistant, working with me, had a face to face encounter with the patient that addresses the primary reason for home health care.

1. Date of the F2F visit: ______/_____/_______ (must be within 90 days prior)
2. Medical Diagnosis for ____
   Home Health Services: ____
3. I certify based on my findings, the following services are medically necessary home health services (List all services): ___________________________________
4. My clinical findings, noted below, support the need for the following home health services because:
   ____
   ____
   ____
5. Type of assistance required to leave the home: _____________________________
   ____
6. I certify that my clinical finding support that this patient is homebound (absences from the home are for medical reasons, religious services or infrequent short duration when for other reasons) because:
   ____
   ____
   ____

PROVIDER TO FOLLOW PATIENT IN THE COMMUNITY: ___________________________________

PROVIDER SIGNATURE: _________________________________ **Date:** ____________________

PROVIDER NAME (Printed): ______________________________