OMNIA HEALTHCARE
www.omniahc.com
755 N Peach Ave Suite G3, Clovis, CA 93611 • 559.772.4673

FROM **FAX FORM TO 559.862.4675**

Physician _____
Office Contact _____
Phone Number _____
Referral Date _____

HOME HEALTH REFERRAL FORM

Patient Name _____ DOB _____ Phone _____
Address _____ City _____ Zip code _____
Emergency Contact _____ Relationship _____Phone _____
Insurance ☐ MEDICARE ☐ MEDI-CAL ☐ OTHER _____ Plan # _____
Please check Home Health services being ordered: ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ MSW

FACE – TO – FACE ENCOUNTER

I certify that this patient is under my care and that I, or the nurse practitioner or physician assistant working in collaboration with me or under my supervision, had a Face to Face encounter on: _____/_____/_____.

Check all that applies:

SKILLED NURSING
- ☐ General Evaluation Observation/ Assessment
- ☐ CAD/CHF/COPD
- ☐ Cardiac Care
- ☐ Catheter Care/Bowel/Bladder
- ☐ Central Line/Port Care _____
- ☐ Enteral Tube Feeding & Education
- ☐ Difficulty Swallowing
- ☐ Enema/Suppository Administration
- ☐ Medication Safety & Management
- ☐ INR Testing Onsite
- ☐ IV Therapy _____x _____days
- ☐ Labs at Home
- ☐ New Disease Management & Education
- ☐ Ostomy Care
- ☐ Oxygen at home (New)
- ☐ Tracheostomy Care
- ☐ Wound Management - location: _____

PHYSICAL THERAPY
- ☐ General Rehabilitation Evaluation
- ☐ Gait & Mobility Safety
- ☐ Fall Prevention
- ☐ Cardio/Pulmonary Rehab
- ☐ Orthopedic Care
- ☐ Pre/Post Hip/Knee Surgery
- ☐ Prosthetics Teaching/Training
- ☐ Total Knee/Hip Replacement

OCCUPATIONAL THERAPY
- ☐ ADL Training
- ☐ Home Safety Evaluation
- ☐ DME Supplies Training
- ☐ Adaptive Devices Training
- ☐ Cognitive Retraining

SPEECH THERAPY
- ☐ General Speech Disorder
- ☐ Dyspraxia
- ☐ Dysphagia

SOCIAL WORKER SERVICES
- ☐ Social/Behavioral Assessment

HOME HEALTH AIDE
- ☐ ADLs

DME/Special Instructions:
_____
_____
_____
_____

TREATMENT ORDER: _____
Additional Order Instructions: _____

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:

Further, I certify that my clinical findings support that this patient is homebound **as evidenced by** *(check all that applies):*
- ☐ Requires assistive device for safe ambulation
- ☐ Non-ambulatory: Confined to bed or chair
- ☐ Limited endurance
- ☐ Requires assistance for another person for safe ambulation
- ☐ Dyspnea with minimal exertion
- ☐ Cognitive impairment

Certifying Physician Name/Signature _____ Date _____

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD or DO ONLY

Please send Face Sheet, History & Physical, Insurance, Medication List via FAX to (559) 862-4675

DOCUMENTATION EXAMPLES FOR FACE-TO-FACE

Justifying the need for SKILLED NURSING:

- Cardiopulmonary Assessment and/or Care
- Neurological Assessment
- Wound Assessment and/or Care
- Administration of IV, SQ or IM injection
- Central Line Care
- Post-op Assessment and/or Care
- Diabetic Teaching
- Monitoring of unstable Blood Sugars
- Monitoring Anticoagulant Therapy
- Mediation Management
- Medication Treatment
- Teaching: Heart Failure Management
- Teaching: Diabetes Mellitus Management
- Teaching: COPD Management

Justifying the need for PHYSICAL and/or OCCUPATIONAL THERAPY

- Assessment of functional deficits and home safety evaluation
- Establish Home Exercise Program
- Restore Joint Function and status post Joint Replacement
- Gait & ADL Training
- Assessment of adaptive equipment needs and environmental modification
- Education on energy conservation techniques

Justifying the need for SPEECH THERAPY

- Therapeutic Exercise to improve swallowing to prevent choking and aspiration pneumonia
- Improve expressive and receptive language skills for medical and social information
- Cognitive communication therapy to improve safety, judgment and memory skills

Supporting HOMEBOUND STATUS

- Requires considerable and taxing effort
- Requires assistive device for safe ambulation
- Requires assistance for another person for safe ambulation
- Non-ambulatory: Confined to bed or chair
- Dyspnea with minimal exertion
- Limited endurance secondary to (List diagnosis/reason)
- Cognitive impairment

A patient who meets Medicare's definition of HOMEBOUND is allowed to leave the home for medical appointments or for non-medical reasons as long as the absences are infrequent and for short periods of time.

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