JEWISH ASSOCIATION ON AGING Celebrating 110 Years 1906 2016

Fast Track Home Health Referral

CMS may request medical records from physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note, and medication profile in your medical record.

Please complete and fax the following information (or attach demographics / face sheet) and office visit note to: 412-586-3268.

PATIENT

Patient Name: _____ SSN: _____

Date of Birth: _____ M F Address: _____

Phone: _____ City, State, ZIP: _____

Alternate Contact Name: _____ Last Flu Vaccine Date: _____

Alternate Contact's Number: _____ Referral Date: _____

Primary Care Physician: _____ Insurance Information: _____
(or attach copy)

Office Contact Name: _____ Office Contact Number: _____

Diagnosis / Medical Condition: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

_____

_____

Skilled Services / Interventions: *(Describe services the nurse / therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

Qualifying Services

☐ *Skilled nursing for:* _____

☐ *Physical therapy for:* _____

Additional Services

☐ *Occupational therapy* ☐ *Social work* ☐ *Home health aide* ☐ *Speech therapy*

Additional Orders: _____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Insert date the face-to-face visit occurred: _____ / _____ / _____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: _____

Physician Signature: _____ **Date:** _____

Physician Documentation

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.

Clinical Findings: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above)*

_____

Homebound Status: *(Describe the clinical and/or physical findings and the functional limitations that result in the patient's normal inability to leave home)*

_____