KLINE GALLAND
HOME HEALTH

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HOME HEALTH REFERRAL

Referring Facility or Clinic: _____ Referral Date: _____

PATIENT INFO

Patient Name: _____ DOB: _____ Sex: □ Male □ Female
Address: _____
City, State: _____ Zip: _____ Phone:_____
Emergency Contact: _____ Contact #: _____ Relationship: _____ □ DPOA

COVID-19 SCREENING

Has the patient or your facility been exposed to positive COVID-19 cases in the last 14 days? □ **Yes** □ **No**

PRIMARY INSURANCE

Payer: □ Medicare MBI # _____
□ Other Insurance: _____ Policy # _____

PHYSICIAN INFO

Referring Physician: _____ Referring MD Phone #: _____
Provider agrees to follow during Home Health episode: □ Yes □ No

For inpatient referrals, please indicate which provider will follow patient in the community for home health episode:
Community following Physician: _____ Provider Phone #: _____

HOME HEALTH ORDERS

Primary diagnosis: _____

□ **Skilled Nursing** Eval & Treatment: _____
□ **Physical Therapy** *Eval & Treatment* : _____
□ **Occupational Therapy** *Eval & Treatment* : _____
□ **Speech Therapy** *Eval & Treatment*: _____
□ **Home Health Aide** Personal Care/Assist with ADLs
□ **Medical Social Worker** *Eval & Treatment:* _____
Notes: _____
_____
_____

HOMEBOUND STATUS

This patient is limited by illness or injury and requires *(please check all that apply)*:

□ Use of an assistive device
□ Reliance on another person for transportation
□ Considerable and taxing effort to leave the home due to: _____
_____
□ Leaving the home is medically contraindicated due to: _____
_____

FACE-TO-FACE ENCOUNTER

Visit within past 90 days: □ **Yes** □ **No** **Face-to-Face Encounter Date**: _____
Please send the completed referral form and attach a copy of the physician's most recent ***signed and dated*** encounter with this patient that supports the reason for the ordered Home Health services. *(See additional document requirements below)*

PHYSICIAN SIGNATURE

Print Physician Name _____ Physician Signature: _____ Date: _____

-OR-

Signature/Credential of Clinician Taking Verbal Order _____
Name of Contact Person: _____ On behalf of Dr._____ Date: _____

KINDLY ATTACH THE FOLLOWING DOCUMENTS TO COMPLETE THE REFERRAL

□ Patient demographics □ History & Physical □ Medication list □ Relevant progress/visit notes
□ Face-to-face visit note □ DPOA Documents *(if applicable)*