



## HOME CARE/HOSPICE REFERRAL FORM FACE-TO-FACE ATTESTATION

**HOME CARE REFERRAL**

**HOSPICE REFERRAL**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ M \_\_\_\_\_ F

PATIENT ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

GUARDIAN/EMERGENCY CONTACT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

MEDICARE#: \_\_\_\_\_

OTHER INSURANCE: \_\_\_\_\_

FOR OFFICE USE ONLY: Pre-Authorization Required: Yes / No      Out of Pocket Cost: \$ \_\_\_\_\_

A Face-To-Face encounter that meets the CMS requirements for this patient occurred on:

DATE OF FACE-TO-FACE ENCOUNTER: \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST HOSPITALIZATION: \_\_\_\_/\_\_\_\_/\_\_\_\_      NAME OF HOSPITAL: \_\_\_\_\_

**PLEASE INCLUDE SUPPORTING FACE-TO-FACE DOCUMENTATION, VISITS NOTES, H & P.**

**BASED ON MY FINDINGS, THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY:**

\_\_\_ **HOME HEALTH CARE SERVICES:**    \_\_\_ NURSING    \_\_\_ SOCIAL WORK    \_\_\_ REGISTERED DIETICIAN  
   \_\_\_ AIDE    \_\_\_ INFUSION

**PRIMARY HOME CARE DIAGNOSIS:** \_\_\_\_\_

**REHAB SERVICES:**    \_\_\_ PHYSICAL THERAPY    \_\_\_ OCCUPATIONAL THERAPY    \_\_\_ SPEECH THERAPY

**MUSCULOSKELETAL REHAB DX:** \_\_\_\_\_

AND/OR

**NEURO/STROKE REHAB DX:** \_\_\_\_\_

\_\_\_ **HOSPICE: TERMINAL DX:** \_\_\_\_\_

**CO-MORBIDITIES:**

\_\_\_ CHF                      \_\_\_ WOUND CARE                      \_\_\_ NEUROPATHY                      \_\_\_ CANCER  
\_\_\_ COPD                      \_\_\_ SEPSIS                      \_\_\_ DEMENTIA                      \_\_\_ SURGERY  
\_\_\_ DM                      \_\_\_ CELLULITIS                      \_\_\_ PARKINSON'S

\_\_\_ OTHER: \_\_\_\_\_

**BASED ON THE ABOVE FINDINGS, I CERTIFY THIS PATIENT IS CONFINED TO THE HOME AND NEEDS INTERMITTENT SKILLED NURSING CARE, PHYSICAL THERAPY, AND/OR SPEECH THERAPY OR CONTINUES TO NEED OCCUPATIONAL THERAPY. THE PATIENT IS UNDER MY CARE; I HAVE INITIATED AND WILL OVERSEE THE PLAN OF CARE.**

PRINT PHYSICIAN NAME: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_      DATE: \_\_\_\_\_