Referral Sheet

AVATAR HEALTHCARE
Home Health • Hospice • PHC

Please fax with patient face sheet, H&P and current medication list.
p: 844-422-5528 f: 844-432-9282 e: staff@avatarhealthcare.com

Name: _____ Male ____ Female ____ DOB _____

Insurance Type: Medicare _____ Secure Horizons ____ Other _____ ID# _____

Clinical Information

Please provide diagnosis related to illness, condition, surgery, etc. pertinent to home health evaluation.

Primary Diagnosis: _____ Secondary Diagnosis: _____

Diagnosis: _____ Surgery: _____ Date: _____

Orders

Skilled nurse to evaluate services ____ Home Health Aide for personal care assist. ____

PT (Evaluate & treat) ____ OT (evaluate and treat) ____ ST (Evaluate & treat) ____

Comments; Additional Orders:

_____

_____

Physician Signature: _____ Date: _____

Home Health Face to Face Encounter Form

(This is a Medicare Requirement)

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face to face encounter that meets the physician face to face requirements on:

Date: (mm/dd/yyyy) _____

The encoutner with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care. That medical condition is identified as follows:

_____

_____

I certify that, based on my findings, the following services are medically necessary home health services (check all that apply):

Skilled Nursing ____ PT ____ Other _____

I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently of short duration when for other reasons) because:

_____

_____

Ordering Physician: _____ UPIN: _____ NPI _____

Physician Signature: _____ Date: _____ Phone: _____

Please include demographic sheet, current office visit note, and HIP