Home Health Care
Referral / Order From
Phone (541) 476-1583
Fax: (541) 476-6227

Home Health Care-Referral/Order Form

Fax this form with a copy of demographic sheet, history & physical and current medications to 541-476-6227 or call 541-476-1583 and we will gladly come pick it up. Thank you.

Patient Information

Name:_____**DOB**_____

Diagnosis_____

Physician Ordered/Requested Services

Admitting Services

Skilled Nursing
- ☐ Evaluation
- ☐ Assessment
- ☐ Labs:_____
- ☐ Wound Care/VAC
- ☐ Medication Management
- ☐ Disease Management

CHF/DM/COPD
- ☐ Caregiver Training
- ☐ Caregiver/Patient education
- ☐ Tele health

Physical Therapy
- ☐ Evaluation
- ☐ Therapeutic Exercise
- ☐ Gait Training
- ☐ Endurance and Strengthening
- ☐ Development of a HEP
- ☐ Caregiving training
- ☐ Wheelchair/equipment evaluation with instructions
- ☐ Lymphedema Treatments
- ☐ Bed mobility/Transfer training

Speech Therapy
- ☐ Evaluation
- ☐ Swallowing Problems
- ☐ Cognitive Skills Training
- ☐ Communication Plan
- ☐ VitalStim Thearpy

COPD /CHF/HIGH RISK patients
- ☐ In home Coumadin monitoring
- ☐ Lymphedema Treatments
- ☐ Other _____

Social Worker (Must have SN or PT ordered)
- ☐ Assess safety/living situation
- ☐ Community resource connection
- ☐ Behavioral Management
- ☐ Other_____

Occupational Therapy (Must have SN or PT ordered)
- ☐ Evaluation
- ☐ Bathing instruction and caregiver education
- ☐ ADL re-training
- ☐ Home safety Management
- ☐ Cognitive skills training
- ☐ Adaptive Equipment Recommendation
- ☐ Low Vision Therapy

Home Health Aide (Must have SN or PT ordered)
- ☐ Bathing/Personal Care needs assistance
- ☐ Monitor Vital Signs

Face To Face Encounter – Please include visit note that supports Home Health Face to Face

MD who performed Face to Face:_____ Phone_____

Date of Last Physician Encounter/Visit_____

The Face to Face encounter with this patient was for the following conditions which are primary reasons for Home Health Services:_____

_____

Home Bound Status is evidenced by the following (i.e. absences from home require considerable and taxing effort)_____

Physician's Signature: _____Date_____