Hope Home Health
6377 Clark Avenue
Dublin, Ca 94568

(925)-829-8770 (P)
(510) 887-4400 (P)
(510) 887-4401 (F)

Home Health Referral Form / Face to Face Encounter

Date of Referral: ____________________

Patient Name: ______________________________ Date of Birth: _________________________

Address: _________________________________ Phone Number: ________________________

Diagnosis: ____

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Insurance & ID#: ☐ Medicare: ________________________ ☐ Private: _____________________

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

☐ Skilled Nursing ☐ Physical Therapist
☐ Occupational Therapist ☐ Speech Therapist
☐ Social Worker ☐ Home Health Aide

I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist or physician's assistant working with me, had a face-to-face encounter with this patient on: **(*Date of Encounter*)** ____

My clinical findings from this encounter support the patient is homebound due to:

- ☐ Leaving home requires a considerable and taxing effort and requires the assistance of another
- ☐ Pain with movement
- ☐ Open draining wound
- ☐ Medically restricted due to immunosuppression, infectious illness, risk of infection, injury, or ____

Special Orders ____

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Assess and call pertinent findings to MD for further follow up

Physician Signature _____________________________ Date Signed: _________________________

Physician Name _________________________________ NPI Number: _______________________

Physician Office address: _________________________ City/ZIP: ____________________________

Office Contact: _______________________________ Office Phone & Fax: _____________________