ComfortCare
HOME HEALTH

Home Health Referral Form

FAX TO:
FAIRHOPE: 251.621.4896
CENTRAL INTAKE: 205.988.4262

PATIENT NAME: ____________________

DATE OF BIRTH: ____ / ____ / ____

PRIMARY CARE PYSICIAN: ____________________

HEALTH INSURANCE INFORMATION: ____________________

PRIMARY DX: ____________________

FACE-TO-FACE ENCOUNTER

PHYSICIAN WHO PERFORMED ENCOUNTER: ____________________

PHONE NUMBER: ____________________

DATE OF LAST PHYSICIAN VISIT: ____ / ____ / ____

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

____

My clinical findings support the need for the home health skilled services **and** homebound status **because**:

____

EVALUATE & TREAT AS INDICATED

QUALIFYING SERVICES

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Speech Therapy

SPECIFIC ORDERS

- ☐ Instruct & Assess Medications
- ☐ Assess & Instruct Disease Process
- ☐ Lab Work (Specify)
- ☐ Wound Care (Specify)

ADDITIONAL SERVICES

- ☐ Occupational Therapy
- ☐ Social Worker
- ☐ Home Health Aide
- ☐ Telehealth
- ☐ Other (Specify)

Specify Items Above:

____

PHYSICIAN SIGNATURE: ____________________

DATE: ____ / ____ / ____