Shamrock Home Care
A PathWell Company

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Home Health Referral Form

Note: A face to face encounter can be completed by a Physician's Assistant and/or Nurse Practitioner but ALL home health orders must be co-signed and dated by a physician

Patient Name:_____ DOB_____
Insurance:
Referring Physician:_____ Phone_____
Face to Face encounter related to current needs for HH occurred on _____
Patients Primary Dx(s) and reason for Home Health:_____
Note: symptom dx codes CANNOT be used for home health referrals

✔️*Check primary discipline(s) being ordered and the Reason(s) why*:
☐Skilled Nursing
☐Physical Therapy
☐ADD on assessments (Circle any/all that apply. Must be in addition to SN or PT):

Occupational Therapy Medical Social Worker Speech Therapy Home Health Aide

Important: Please attach the following to this referral form:
☐Patient demographics, including insurance information
☐Most recent **F2F visit note** from physician
☐Most recent H&P, listing primary dx and comorbidities
☐Current medication list

Homebound Status Certification (required)

Due to the above stated illness, injury or surgical procedures (medical condition or diagnosis) and associated clinical findings, I certify that the patient is homebound because of his/her inability to leave the home except with the aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated.

Required: Please complete this table to meet homebound eligibility criteria

Patient requires the following assistance to leave the home (check all that apply)
☐Cane ☐Walker ☐Wheelchair ☐Aid of another person ☐Medically Contraindicated

Physician Signature:_____**Date**:_____