



Physician Referral Hot Line
631-465-1800

**PLEASE FAX REFERRALS TO
631-465-6855**

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Patient's Name: _____

Address: _____ City: _____ Zip: _____

Patient's Phone: _____ Date of Birth _____ Gender: () Male () Female

Emergency Contact Person outside the Home. (Name/#) _____

Insurance Name: _____ Policy # _____

Insurance Name: _____ Policy # _____

Primary Diagnosis: _____

Comorbidities:

<input type="checkbox"/> CAD	<input type="checkbox"/> CHF	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Cancer	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other (specify)

1. Has the patient been in a hospital or skilled nursing facility in the past 14 days?

Yes No Unknown

2. Have any new medications been added and /or existing medication changed in the past month?

Yes No Unknown

- RN Evaluation Behavioral Health Infusion Wound Care
- Physical Therapy Occupational Therapy Speech Language Pathology Medical Social Worker

Special Instructions: _____

Please attach CURRENT MEDICATION RECORD AND LAST PHYSICIAN OFFICE VISIT NOTE

Face to Face Encounter Certification

I certify that a Medicare enrolled physician or a non-physician practitioner performed a face to face encounter on the above patient **on** _____.

The clinical findings of this encounter support that the patient is homebound and in need of intermittent **Skilled Nursing and/or therapy (Physical Therapy or Speech Language Pathology)** and are documented below.

Dr. Name's (printed) _____

Address: _____

Phone: _____

License: _____ NPI # _____

Doctor Signature: _____ Date: _____