Catholic Health
Home Care

Physician Referral Hot Line
631-465-1800

PLEASE FAX REFERRALS TO
631-465-6855

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:

□ CAD	□ CHF	□ Diabetes	□ Neuromuscular Disorder	□ Peripheral Neuropathy
□ Cancer	□ COPD	□ Hypertension	□ Osteoarthritis	□ 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: _____