BRADENTON	FAX 941-727-4112	FORT MYERS	FAX 239-561-6742
SARASOTA	FAX 941-925-2044	PT CHARLOTTE	FAX 941-235-0275
SEBRING	FAX 863-658-2845	LABELLE	FAX 863-675-6745
ENGLEWOOD	FAX 941-474-5900	NAPLES	FAX 239-354-9836

REFERRAL FORM/FACE TO FACE

Patient Name ____

Address ____ DOB _______________

City/State/Zip ____

Medicare # ______________________________ Phone _________________________________

Diagnosis/Medical Condition/Symptoms/Primary reason for home care: ______________________

____

Based on findings, disciplines requested: ☐ SN ☐ PSYCH ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ HHA

Clinical findings supporting need for services: ____________________________________

____

Clinical findings that support patient's homebound status: ____________________________

____

Specific Orders (i.e. Labs, wound care, etc): ______________________________________

____

Please attach ** Patient's Medical History & Last Office Visit Note

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with the patient on **(Insert date that visit occurred): ________________________.**

I certify that, based on my findings, the above services are medically necessary home health services.

Physician Full Name *(print)* ____

Physicians Signature: (***no stamps***) ____ Date: ____________

Mandatory that Physician must sign and date this form date this form