Referral/Physician Order Form

To: Angels 2 You LLC Home Health Care	**From:**
Fax: 915-581-8907	**Pages:**
Phone: 915-581-0909	**Date:**

RE: Patient's Name: _____ D.O.B.: _____ Phone #: (_____)_____
SSN: _____ Patient's Street Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact Name: _____ Phone #: (_____)_____

Coverage:

□ Medicare ID: _____
□ Medicaid ID: _____
□ Other Insurance Name: _____ID:_____

Face to Face Encounter:

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 this patient on: (Insert date that visits occurred): _____/_____/_____
Month Day Year

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):
_____
_____
_____

I Certify that, based on my finding the following services are medically necessary for home health services (check all that apply):

_____ Skilled Nurse _____ Speech Therapy _____ Other:
_____ Physical Therapy _____ Home Health Aide
_____ Occupational Therapy _____ Medical Social Worker

My clinical findings support the need for the above services because:
_____
_____
_____

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:
_____
_____
_____

Physician's Signature: _____ Date: _____