Dominion Home Health Care

"Our Focus Is On You"

Home Health Care Fax Referral Form

Phone: 703-533-3060 ● Fax: 703-533-3061

www.dominionhcs.com

GENERAL PATIENT INFORMATION

Name		Social Security:	
Current Address:	**City:**	**State:**	**Zip Code:**
Date of Birth: / / 19	**Best Contact Phone#:**		

INSURANCE INFORMATION

Medicare #	Primary Insurance Name	Primary Insurance Policy #
Other#	Secondary Insurance Name	Secondary Insurance Policy #

ORDERS INFORMATION

- ❑ Skilled Nurse To Evaluate For Home Care Needs
- ❑ Physical Therapy Evaluation & Treatments
- ❑ Occupational Therapy Evaluation & Treatment
- ❑ Speech Therapy Evaluation & Treatments
- ❑ Medical Social Worker Evaluate for Local Resources

Lab Orders: _____

Wound Care Orders: _____

_____

Others:

"FACE TO FACE ENCOUNTER" DOCUMENTATION

If Patient's Primary Insurance Is Traditional Medicare, Please Complete This Section:

1. **Primary Diagnosis & Reason for Home Health Care Referral:** _____

2. **Date of Last Face To Face Encounter:** _____/_____/_____
   (***Traditional Medicare patients are required to have a face to face encounter with a MD, APRN or PA within 90days prior to, or 30 days following, the start of home care***)

3. **Clinical Findings To Support Need For Home:** _____

   _____

4. **REASON PATIENT IS HOMEBOUND**: _____

PHYSICIAN SIGNATURE: _____ **DATE** _____/_____/_____

PRINT NAME: _____ **PHONE:** _____

********Please Fax Physicians Referral Form to 703-533-3061********

1. **PATIENT FACESHEET & PHYSICIANS ORDERS**
2. **HISTORY AND PHYSICAL OR OFFICE NOTES**
3. **INSURANCE CARD COPY (if available)**

For Office Use:

Referral Date: _____/_____/_____

Received By: _____