



**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:**

- Primary Diagnosis & Reason for Home Health Care Referral:** \_\_\_\_\_
- 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)
- Clinical Findings To Support Need For Home:** \_\_\_\_\_  
 \_\_\_\_\_
- REASON PATIENT IS HOMEBOUND:** \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 PRINT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

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

- PATIENT FACESHEET & PHYSICIANS ORDERS**
- HISTORY AND PHYSICAL OR OFFICE NOTES**
- INSURANCE CARD COPY (if available)**

**For Office Use:**

Referral Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Received By: \_\_\_\_\_

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