Home Health Referral Fax Sheet

Patient Name:_____ DOB:_____ SSN:_____

Patient's Home Address:_____

Insurance Provider: (Medicare/Medicaid/Other)_____

Referring Agency:_____

Referring Provider:_____ NPI: _____

To help us determine if this patient is appropriate for Home Health, we ask that you fax the following info to **(620) 724.4790.**

- ☐ Signed Physician Order for Home Health (Skilled Nursing, Home Health Aide, PT, OT, SP)
- ☐ Skilled Need/Diagnosis(Reason for Admission)
- ☐ Discharge instructions sign by patient/nurse
- ☐ H & P
- ☐ Dressings/wounds/treatment/Sutures/Staples/Ports/SC/Heplock
- ☐ Current labs & imaging
- ☐ Home medication List
- ☐ Homebound for Medicare

If the patient has any of the following needs, please indicate, as we may need to coordinate services before we receive the patient.

☐ Wound Vac ☐ Ostomy Care ☐ Central Line Maintenance ☐ Dressing Changes

☐ Other:_____

To insure continuity of care, please fax the following documents before patient leaves your facility:

☐ Provider Orders ☐ Discharge Summary & Instructions ☐ Discharge Med List

We appreciate your referrals and will be happy to answer any questions on the appropriateness of a patient. To make a referral or with questions, don't hesitate to get in touch with our Home Health Department at **(620) 724.8469.**

Home Health Coordinator
Fax: (620) 724.4790
Phone: (620) 724.8469
www.GirardMedicalCenter.com

GIRARD Medical Center

Home Health Order Form

Summary/Title:_____

(Example: PT, OT, SN, HHA)

Orders: (Please be specific)

Physician Name:_____

Physician Signature:_____ **Date:** _____

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