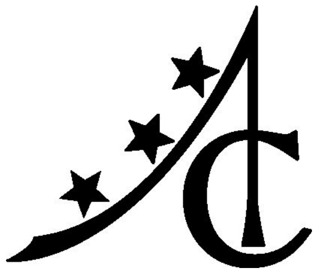

AmeriCare
Home Health Services, Inc.
5020 Tamiami Trail N • Suite 200
Naples, FL 34103
Phone (239) 261-0313 • Fax (239) 307-4538

PATIENT REFERRAL FORM

Patient Name: ____ DOB: ___________________

Address: ____ Phone: ___________________

Social Security #: ______________________

Insurance Information: ____________________________ Medicare # : _______________________

Diagnosis:____

____

Nursing:

___ Skilled Observation/Assessment

___ Medication Management/Teaching

___ Home Health Aide **

___ Social Worker **

Therapy:

___ PT Evaluation/Treatment

___ ST Evaluation/Treatment

___ OT Evaluation/Treatment **

** not a Medicare qualifying skill

Specific Instructions/Orders: ____

____

____

____

CERTIFICATION OF FACE TO FACE ENCOUNTER FOR HOME CARE SERVICES

I certify that a * qualified face to face encounter occurred on ________ with the above mentioned patient for the following medical condition (s) ____

____

The following clinical findings support that the patient is homebound and that the patient needs intermittent skilled nursing, physical therapy and/or speech-language pathology: __________________________________

____

____

___________________________	___________________________	___________
Certifying Physician Signature	Certifying Physician Printed	Date

* The physician must document when the physician or allowed non-physician practitioner (NPP) saw the patient and documented how the patient's clinical condition as seen during that encounter supports the patient's homebound status in need for skilled services. The face-to-face encounter must occur within 90 days prior to the start of home health care, or within the 30 days after the start of care.