Professional
Heath Care Network

REFERRAL FORM

PLEASE FAX THIS FORM ALONG PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION FORM TO:833-481-3441
Phone: 888-705-5274 Online: www.prohcn.com

Date of Request:_____

Referral Source: ☐ House Calls ☐ Welcome Home ☐ Hospital ☐ SNF ☐ Physician Office

Member Name: _____

DOB: _____

Member Address: _____

_____

Emergency Contact POA Name, Relationship and Number:

_____

Member Preferred Language: _____

MD/DO/NP/PA/DPM Name: _____

Office/Facility Address: _____

NPI: _____

Name of Contact at Office/Facility:_____

Phone: _____ Fax: _____

Health Plan Name: _____

Member ID (Required): _____

Medicare HICN/Medicaid ID# _____

Primary Diagnosis (include ICD-10 codes):

_____

Past Medical Hx/Secondary dx:

_____

_____

Member's assigned PCP:

_____

Care Type Required:

- ☐ Drain
- ☐ Foley Cath Care
- ☐ Feeding Tube
- ☐ LVAD
- ☐ Lovenox Injections
- ☐ Nephrostomy Tube
- ☐ New Insulin Dependent Diabetic
- ☐ Ortho
- ☐ Ostomy Care
- ☐ PleurX Cath
- ☐ Trach
- ☐ Wound Care
- ☐ Wound Vac
- ☐ None of the above

ADMIT TO HOME HEALTH SERVICES FOR:

☐ **SKILLED NURSING (G0299):**

- ☐ Multi-System Assessment / CPA
- ☐ Wound / Skin Assessment *Include Wound Notes and Specific Wound Care Orders*
- ☐ Medication Management / Teaching
- ☐ Foley Cath Care: Cath Size _____ Freq._____

☐ **PHYSICAL THERAPY (G0151):**
- ☐ Eval and Treat, Home Safety Eval

☐ **OCCUPATIONAL THERAPY (G0152):**
- ☐ Eval and Treat

☐ **SPEECH THERAPY (G0153):**
- ☐ Eval

☐ **HOME HEALTH AIDE (G0156):**
- ☐ Bathing / Grooming Assist

☐ **MEDICAL SOCIAL WORKER (G0155):**
- ☐ Community Resources, Long Term Care Planning

REQUIRED INFORMATION: ☐ Supporting Clinical Documentation (F2F if available, Visit Notes, H&P) ☐ MD, DO, NP, DPM, or PA Signed Home Health Order ☐ Medication List ☐ Discharge Summary

Additional Order details and Interventions:

For Medicare Beneficiary: The F2F encounter date must be within 90 days prior or 30 days after the date of home care admission and related to the reason for the home care referral.

I certify that this patient is under my care and that I, or a NP/PA working with me, had a face-to-face encounter on _____, _____, _____
day month year

Name of Provider whom saw patient: _____

I certify that based on my findings, this patient is **homebound** and needs intermittent SN, PT, OT, ST, MSW which are medically necessary.

Ordering Physician Name: _____ NPI: _____

Physician signature: _____ Date / Time signed: _____