FAST TRACK REFERRAL FORM

Please complete and fax the following information and office visit note to: (281) 980-7974

PATIENT

Patient Name: _____ SSN: _____

Date of Birth: _____ M ___ F___ Address: _____

Phone: _____ City, State, Zip: _____

Alternate Contact Name: _____ Referral Date: _____

Alternate Contact's Number: _____

Primary Care Physician: _____ Insurance Information: _____

Office Contact Name: _____

Office Contact Number: _____

DIAGNOSIS/ MEDICAL CONDITION: (List the diagnosis/ medical conditions that are the primary reason the patient requires home health care.)

_____

_____

SKILLED SERVICES/ INTERVENTIONS: (Describe services the nurse or therapist will perform in the home.

- ☐ Skilled Nursing: _____
- ☐ Physical Therapy: _____
- ☐ Speech Therapy: _____
- ☐ Occupational Therapy: _____
- ☐ Social Work: _____
- ☐ Home Health Aide: _____

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CERTIFICATION FOR FACE- TO – FACE ENCOUNTER

I certify that this patient is under my care and that I, a nurse practitioner, a PA working with me, or a physician who cared for the patient in an acute or post- acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

FACE- TO-FACE ENCOUNTER DATE _____/_____/_____

Bb Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care, and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: _____

Physician Signature: _____ **Signature Date:** _____

OPTIONAL PHYSCIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare au

CLINICAL FINDINGS: (Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)

_____

_____

HOMEBOUND STATUS: (Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home)

_____

_____