# HOME HEALTH CARE
# REFERRAL FORM

**Region 4: Keystone Heights**
Referral Fax 352-478-7035
Phone: 352-478-7030

**www.legacyhhc.biz**

**Region 3: Starke**
Referral Fax: 866-530-1994
Phone: 904-964-3712

**Region 3 Branch: Ocala**
Referral Fax 352-201-3408
Phone: 352-421-5616

**Contact Phone:** ______________________________ **Contact Email:** ______________________________

**FAX THIS FORM** including the patient history and physical to the number listed above.

| | |
|---|---|
| Patient Full Name: | DOB: __ / __ / ____ |
| Phone: | Email: |
| Address/Services Location: | City: / Zip: |
| Medicare#: | ICD 10 Code: |

**The patient is homebound due to the following:**

**Select at least one:**
- O Needs **supportive devices** to leave home
- O Needs **assistance from others** to leave home
- O **Leaving home is medically contraindicated**

**Select both:**
- O There exists a normal **inability to safely leave** home
- O Leaving home **requires a considerable and taxing effort**

## ■ SKILLED NURSING

**Select at least one:**
- O Evaluation and Treatment
- O Medication Education/Mgmt.
- O Nutritional Support
- O Observation/Assessment of Condition
- O Patient/Family Education
- O Home safety Education
- O COPD Care
- O CHF Care
- O Diabetic care
- O Catheter care
- O Ostomy care
- O Wound care

## ■ PHYSICAL THERAPY

- O Gait/Transfer Therapy
- O Balance Training
- O Orthopedic Services
- O Vestibular Rehab
- O Establish Home Exercise Program
- O Adaptive/Assist Device Education
- O Fall Prevention/Safety Education
- O Pain Management
- O Cardiovascular Rehab
- O Neurological Rehab

## ■ OCCUPATIONAL THERAPY AND TRAINING

- O Self-Care Management
- O Work Simplification
- O Task Segmentation
- O Energy Conservation

## ■ SPEECH THERAPY

- O Speech Dysphasia Treatment
- O Dysphagia Treatment
- O Language Processing
- O Communication System

## ■ MEDICAL SOCIAL SERVICES

- O Crisis Intervention
- O Psychosocial Assessment
- O Community Resources

## ■ HOME HEALTH AIDE

- O Bathing and ADL Assistance

## ■ PHYSICIAN INFORMATION

Date of most recent physician visit: __ / __ / ___

Physician's Orders and/or Special Requests: ______________________________

PCP, if different: ______________________________

**Physician/Provider Signature:** ______________________________ **Date:** __ / __ / ___

**Physician/Provider Name PRINTED:** ______________________________ MD__DO__DPM__

■ **I HAVE ATTACHED A COPY OF THE PATIENT MEDICAL HISTORY AND PROGRESS NOTES WITH SUPPORTING DIAGNOSIS**

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