HOME HEALTH CARE
REFERRAL FORM

www.legacyhhc.biz

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

Region 3: Palatka
Referral Fax 866-494-1511
Phone: 386-312-7411

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

Region 3: 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 Observation/Assessment of Condition	O COPD Care	O Catheter care
O Medication Education/Mgmt.	O Patient/Family Education	O CHF Care	O Ostomy care
O Nutritional Support	O Home safety Education	O Diabetic care	O Wound care

■ PHYSICAL THERAPY

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