VISITING NURSE SERVICE & HOSPICE OF SUFFOLK

VNSHS CERTIFIED HOME HEALTH CARE REFERRAL FORM

Phone: 631.930.9375 Fax Referral: 631.912.1114

Please download additional forms at: visitingnurseservice.org

PATIENT INFORMATION

Last Name ______________________________

First Name ______________________________

Address ______________________________

City______________ State________ Zip__________

Phone #1 ______________________________

Phone #2 ______________________________

Date of Birth______________ ❑ Male ❑ Female

Emergency Contact/Relationship ______________________

____

Day Phone ______________________________

Evening Phone______________________________

INSURANCE INFORMATION

Medicare #______________________________

Medicaid # ______________________________

Insurance Carrier Name ______________________

____

Subscriber Name ______________________

Policy # ______________________________

WC Y ❑ N ❑ NF Y ❑ N ❑

REASON FOR REFERRAL

- ❑ General Home Care
- ❑ Hospice
- ❑ Palliative Care Program
- ❑ Telehealth

***Mandatory, attach the following:**

- ❑ Last Office Note
- ❑ Current List of Medications
- ❑ History and Physical

FACE –TO-FACE ENCOUNTER CERTIFICATION

MEDICARE AND OTHER REQUIRED INSURERS ONLY

Patient Name ______________________________

I certify that a face-to-face encounter was performed on the above named patient on______/______/______by who is a ❑ Medicare enrolled physician or ❑ a permissible non-physician practitioner. The clinical reason for the encounter was:

____

____

The patient's clinical condition, as observed during the encounter, supports the patient's homebound status as follows:

____

____

FOR ALL PATIENTS

The patient's **clinical status** supports the need for the following skilled services/tasks:

- ❑ Skilled Nursing Care ______________________________
- ❑ Physical Therapy ______________________________
- ❑ Occupational Therapy ______________________________
- ❑ Speech/Language Therapy ______________________________

Certifying Physician Signature______________________________Date______/______/______

Print Physician Name______________________Address______________________

Phone______________________Fax______________________