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 # _____

REASON FOR REFERRAL:

❑ General Home Care

❑ Palliative Care Program

❑ Telehealth

PLEASE PROVIDE ALL MANDATORY CLINICAL DOCUMENTATION FOR FACE TO FACE TO SUPPORT HOME CARE SERVICES:

❑ MD Encounter Note required for Face to Face to Support Home Care Services

❑ Completed Face to Face Form Below

❑ 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 _____