Today's Homecare, Inc.
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Home Care Referral

Patient Name: _____ Sex: ___ Date of Birth: _____
Address: _____ Phone: _____
City: _____ Zip: _____ Language: _____
Medicare: _____ Medicaid/Other: _____
Social Security: _____ Allergies: _____
Emergency Contact: _____ Phone: _____
Physician Name: _____ Phone: _____ Fax: _____

1. Certification and Date of Face to Face Encounter

I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist or physician's assistant working with me, had a face to face encounter with this patient on: _____ (Date of Encounter)

2. Medical Condition Related to Home Health Services

The Encounter with the patient was in whole, or part, for the following medical condition, which is the primary reason for home health care: _____

3. Certification of Medical Necessity

I certify that based on my clinical findings the following services are medically necessary for home care services (check all that apply)

□ Skilled Nursing for: _____

□ Physical Therapy for: _____

□ Occupational Therapy for: _____

□ Speech/Language Therapy for: _____

4. Certification of Homebound Status

My clinical findings from this encounter support the patient is homebound due to:

□ Leaving home requires a considerable and taxing effort

□ Absence form home are infrequent, of short duration or to receive healthcare treatment

□ Medically restricted due to immunosuppression, infectious illness, risk of infection or injury, or: _____

Physician Signature: _____ Date: _____

NPI: _____ License Number: _____

Address: _____

Print Name: _____