Today's Homecare, Inc.
Phone: 718-737-8012 | Fax: 855-289-2365
2575 East 14 Street, Unit C1, Brooklyn, NY 11235 | Info@todayshc.com

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Dear Doctor please fill out this form, for your patient, please include the last progress notes, medications list and fax everything back to us 855-289-2365. Thank you.

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: ____