MedStar Visiting
Nurse Association

FAX COVER SHEET

Home Healthcare Referral

FAX to: 888-862-6082

Referral Documentation Checklist

Type of Referral: ☐ Start of care ☐ Resumption of care

Documents/information needed:

- ☐ Demographic sheet to include:
  - Patient's first and last name
  - Address and phone number of where patient will receive homecare services
  - Email address
  - Patient's primary language
  - Patient-selected representative or power of attorney
  - Insurance information
  - Emergency contact information
- ☐ For patients with **primary or secondary Medicare or Medical Assistance**, a completed Face-to-Face encounter document must be signed by a **physician** (PA or NP signature not acceptable)
- ☐ Physician's homecare order (if Face-to-Face document not required)
- ☐ Referring physician's name and phone number
- ☐ Name and phone number of the physician who will be following the patient for home care services
- ☐ Medication profile
- ☐ Hospital transfer/discharge summary (if applicable)
- ☐ History and physical

Additional items needed for infusion referrals:

- ☐ Current labs
- ☐ Signed physician's order with medication, dose, frequency and duration
- ☐ PICC line X-ray, tip placement, length of PICC line
- ☐ Lab/blood work orders (if applicable) and the physician who should receive the results

Questions? Call The Patient Intake Center at **800-862-2166.** Choose option 2.

FURTHER ACTION REQUIRED! Fax submission does not guarantee start-of-care. Please call to verify receipt and confirm start-of-care date.

Knowledge and Compassion
Focused on You

Face-to-Face Progress Note and Home Health Orders

IMPORTANT: For orders to be carried out, you must check the box next to the **service** needed (services identified by bold letters). Initial certification and orders must be signed and dated by attending physicians. The Home Health Orders portion of the form for resumption of care or an update to the initial certification can be completed by any provider.

Patient name:	**Patient DOB:** _____/_____/_____ Month Day Year
Anticipated date of discharge: (applies only to hospital or facility)	
Attending physician expected to follow patient: (first and last name)	
Attending physician phone number:	

Face-to-Face Encounter occurred on: _____/_____/_____ (should be within 90 days of start of care)
Month Day Year

Is this visit related to the primary reason the patient requires home health services? ☐ Yes ☐ No

Clinical Findings

Patient's medical condition or diagnosis of _____results in:
Check all that apply

☐ Instability ☐ Unsteady gait ☐ Immune-compromised
☐ Muscle weakness ☐ Non-weight or partial weight bearing ☐ Pain with ambulation
☐ Generalized weakness and fatigue ☐ Wound infection or non-healing wound ☐ Shortness of breath
☐ Other:_____

Homebound Status

Due to the above stated illness, injury or surgical procedure (medical condition or diagnosis) and associated clinical findings, the patient is homebound because of his/her inability to leave home except with aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated.

REQUIRED: Must complete both sections of this table to meet homebound eligibility criteria.

Patient requires the following assistance to leave the home: (Check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Aid of another person ☐ Medically contraindicated

AND (required)

Patient cannot leave the home or requires assistance to leave the home because: (Check all that apply)

☐ High fall risk due to gait instability
☐ Muscle weakness
☐ Cognitive deficits impact judgment, impair ability to safely navigate and prevent decision making for safety
☐ Shortness of breath/distress after ambulating more than 10 feet results in high risk for falling
☐ Recent lower/upper extremity surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation
☐ Patient is bedbound due to:_____
☐ Other: _____

Home Healthcare Orders

☐ **Skilled Nursing** [Check all that apply]

- ☐ Medication management (specify): _____
- ☐ Anticoagulation
- ☐ New cardiovascular medications
- ☐ Diabetes Mellitus Assessment/Teaching
- ☐ Cardiovascular Cardiopulmonary (CV/CP) Assessment
- ☐ Wound Care: (specify wound care and treatment)_____

_____

- ☐ Other: _____

Patient name: _____

☐ **Infusion Therapy** [Check all that apply]

☐ **IV medications** [ie: antibiotics, chemotherapy, etc]

Name and dosage:		
Frequency and duration		
Type of line:	Location:	Date of insertion:

☐ **TPN** [requires a completed TPN Order Form indicating type of formula]

Start Date:	Type of Line:
Location:	Date of Insertion:

☐ **Cathflo® (Alteplase)** 2mg for each occluded lumen, per manufacturer instruction, as needed, while patient is on IV therapy.

☐ **Tube Feeding** [requires a completed Tube Feeding Order Form indicating type of formula]

Start Date:	Date of Insertion:
Type of Tube ☐ PEG ☐ PEJ ☐ Other (specify)	

☐ **Labs** [Check all that apply]

☐ Venipuncture (specify): _____

☐ PT/INR:_____times/week. ☐ May use PT/INR meter.

- Planned date for first INR:_____
- Goal INR Range:_____

☐ Other Labs – specify type and frequency: _____

Send results to:_____ Phone: _____ Fax: _____

☐ **Therapy Orders** [Check all that apply]

☐ **Physical Therapy** ☐ **PT assess for OT** ☐ **Occupational Therapy** (must have skilled nursing or PT ordered) ☐ **Speech Language Pathology**

☐ Provide gait training, strengthening and/or balance exercises to restore the patient's ability to walk safely without pain.

☐ Increase strength and endurance and restore ROM s/p_____surgery.

☐ Evaluate for assistive devices and/or environmental modifications needed to address ADL deficits to improve safety with transfers and ambulation.

☐ Teach the patient caregiver compensatory strategies for cognitive deficits.

☐ Teach patient caregiver compensatory environmental modifications for safety.

☐ Evaluate and treat dysphagia.

☐ Evaluate and treat aphagia.

☐ Provide maintenance therapy to prevent or slow a decline in condition.

☐ Other (describe):_____

☐ **Medical Social Worker** [Must also have skilled nursing, physical therapy or speech therapy ordered]

☐ **Home Health Aide** [Not PCA service; must also have skilled nursing, physical therapy or speech therapy ordered]

Signature: **NPI #:** **Date: / / Time:**

Print Name: **Pager/Phone:**

NOTE: Initial certification and orders must be signed and dated by attending physicians. The home health orders portion of the form for resumption of care or an update to the initial certification can be completed by any provider. (Revised: 04.10.17)