



MedStar Health

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 our 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.

MedStar Health Home Care Face-to-Face Progress Note and Home Health Orders

Initial certification and orders must be signed and dated by the ordering provider. (MD, PA, NP)

Patient Name: _____ **Patient DOB:** ____/____/____

Face-to-Face Encounter occurred on: ____/____/____ (should be within 90 days of start of care)

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 Muscle weakness Generalized weakness and fatigue Unsteady gait Non-weight or partial weight bearing
 Wound infection or non-healing wound Immune-compromised Pain with ambulation 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.

MUST COMPLETE BOTH SECTIONS BELOW 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

***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 Wound infection or non-healing wound Patient is bedbound 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 LE/UE surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation.
 Other: _____

Advance Directives: YES NO

Do Not Resuscitate: YES NO

MOLST Form (patients living in Maryland): YES NO

Home Healthcare Orders

Skilled Nursing (Check all that apply)

- Medication management Disease Management Nutritional Management Drain Care
 Anticoagulation New cardiovascular medications Diabetes Mellitus Assessment/Teaching
 Cardiovascular Cardiopulmonary (CV/CP) Assessment
 Wound Care: (specify wound care, negative pressure wound care and treatment) _____

Other _____

Patient Name _____

Infusion Therapy (Check all that apply)

• **IV medications** (antibiotics, chemotherapy, pain, cardiac)

Name and dosage: _____

Frequency and duration: _____

Type of line: _____ Location: _____ Date of insertion: _____

Line Flush Instructions: _____

• **TPN**

Formula and dosage: _____

Start Date: _____ Type of Line: _____

Location: _____ Date of Insertion: _____

Line Flush Instructions: _____

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

• **Tube Feeding**

Enteral Formula and dosage: _____

Start Date: _____ Route: PEG PEJ Administration Method: Pump Gravity Bolus

Flush Instructions: _____

Labs (Check all that apply)

Venipuncture: CBC BMP LFT CMP CRP & ESR CK Vanc Level (random) Vanc Level (trough)

Other _____

PT/INR: _____ times/week. May use PT/INR meter.

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

Send lab results to: _____ Phone: _____ Fax: _____

Therapy Orders (Check all that apply)

Physical Therapy PT assess for SN PT assess for OT **Occupational Therapy** **Speech Therapy**

(must have nursing or PT ordered)

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 ordered)

Referring Provider Information (physician, PA, NP)

Provider Signature: _____ NPI #: _____ Date: _____ Time: _____

Print Name: _____ Pager/Phone: _____

Physician Practice or Clinic Name: _____ Phone #: _____