HOMECARE REFERRAL FORM

To be completed by a referring provider. Physician signature required on Page 2.

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: ____ / ____ / _____ Gender: _____ Phone: _____

Address: _____ City: _____State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____Phone: _____

Address: _____ City: _____State: _____ Zip Code: _____

LEGAL GUARDIAN (if applicable)

Name: _____ Phone: _____

Address: _____ City: _____State: _____ Zip Code: _____

LANGUAGE & SERVICES

Language(s) Spoken: ☐ English ☐ Spanish ☐ Other (specify): _____	**Other Services Patient is Currently Receiving:** ☐ GAFC ☐ AFC ☐ PCA ☐ Adult Day Care ☐ Other (Specify): _____

INSURANCE INFORMATION

Primary Insurance:

Payer Name: _____ Policy Number: _____

Secondary Insurance:

Payer Name: _____ Policy Number: _____

MassHealth Number: _____ **Medicare Number:** _____

Self-Pay: ☐ Yes ☐ No ☐ Other (Specify): _____

(Must be completed and signed/co-signed by patient's doctor)

To _____,
You are receiving this request because our agency was contacted about your patient's need for services at home. By signing this order, you will be consenting to an initial home assessment by one of our home care nurses within 24-48 hours (unless postponed due to client/family conflict with scheduling). A proposed plan of care will be sent for your review, including any other suggestions.

REFERRAL DETAILS

Order: *Assess and, if appropriate, admit to Homecare*

Reasons for Referral:

_____

_____

Requested Services: ☐ Skilled Nursing ☐ AFC ☐ HHA ☐ PT ☐ OT ☐ Other: _____

Patient Diagnosis:

_____

_____

I certify that this patient is under my care and that I or a Nurse Practitioner or Physician's Assistant had a **F2F (face to face)**

encounter on: **Month:** _____ **Day:** _____**Year:** _____

REFERRING PROVIDER INFORMATION

Provider Name: _____ NPI #: _____

Phone: _____ Fax: _____

Address: _____ City: _____State: _____ Zip Code: _____

PHYSICIAN SIGNATURE

Signature: _____ Date: ____ / ____ / _____

NOTES TO PHYSICIAN

- Please include the most recent medication list and office visit/diagnosis note with this referral.
-Services will typically begin within 24–48 hours after receiving this signed form.
- Availability of services depends on the patient's payer source; we will notify you if we are unable to proceed.
-A Registered Nurse will conduct a full assessment and collaborate with the patient and physician to finalize a Plan of Care.