FAX COVER SHEET

Ohio Valley Home Health Referral

FAX: 812-949-6296

Referral Documentation Checklist

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

Documentation Checklist:

- ☐ F2F Encounter - **primary or secondary Medicare or Medicaid**, a completed Face-to-Face encounter document ***must*** be signed by a certifying MD, MD who cared for patient in acute/post-acute facility, APRN, Clinical Nurse Specialist, Certified nurse-midwife, or a Physician Assistant*
- ☐ Physician's home healthcare order (if Face-to-Face document not required)*
- ☐ H&P/ MD office visit note*
- ☐ Hospital transfer/discharge summary*
- ☐ Progress notes
- ☐ Operative notes
- ☐ Consultations
- ☐ PT/OT/ST evaluations
- ☐ Medication profile*
- ☐ Pertinent labs
- ☐ X-ray/other diagnostic reports

****MUST HAVE***

Additional items needed for infusion referrals:

- ☐ Current labs
- ☐ Signed physician’s order with medication, dose, frequency, and duration
- ☐ PICC x-ray, tip placement, and length of catheter
- ☐ Lab orders and the physician who should receive the results

Questions? Call 812-944-9284 and ask to speak the Clinical Manager or the Administrator.

FURTHUR ACTION REQUIRED! Faxed referral does not guarantee start of care. Please call to verify receipt and confirm start of care date.

Face-to-Face Progress Note and Home Health Orders

Demographics	Patient Name: ____________________ DOB: ____________ Address: ____________________ Phone #: __________ Email: ____________ Gender: ❑Female ❑Male Primary Language: ____________________
Insurance	Medicare#: ______________ Medicaid#: ______________ Primary Payor: ______________ 2nd Payor: ______________ Medicare Advantage/#: ______________ Auth Required: __________ SSN: _____/____/______ Eligibility checked by/date: ______________
Contacts/PCG/AD	Primary Contact/Caregiver: ____________________ Relationship: ______________ Phone#: ______________ Secondary Contact/Caregiver: ____________________ Relationship: ______________ Phone#: ______________ Patient-selected representative: ____________________ Legal Representative/Type: ____________________ Advance Directives: ______________ Code Status: __________
Referral Information	Referral Date: ______________ Anticipated Start Date: ______________ Referring Source: ❑Institutional ❑Community Source Name: ______________ Discharge Facility: ______________ D/C Date: ______________ Referring Physician: ______________ Phone#: ______________ Physician to follow patient/sign orders: ____________________ Physician phone#: ____________________
Face To Face	MD/NPP: ______________ F2F Visit Date: __________ F2F 90 days prior to start of care? ❑Yes ❑No F2F visit related to the primary reason the patient requires home health services? ❑Yes ❑No Scheduled/Pending F2F: __________ F2F within 30 days of start of care? ❑Yes ❑No

Clinical Findings:

Patient's medical conditions or diagnoses of

____

____

(Avoid symptoms, muscle weakness, unsteady gait, joint pain not attributed to a disease process, skin tears, abrasions) results in/or establishes a need for:

Check all that apply:

SN					
❑Observation & Assessment:	❑Wound/ Ostomy care:	❑ Medication Mgmt:	❑Infusion/ABT Therapy:	❑Disease Mgmt:	❑Surgical Aftercare:
❑Educate/teach:	❑Catheter/Tube care:	❑Labs (not a stand-alone service):	❑Other:		
PT					
❑Eval & Treat:	❑ ADL Training:	❑Therapeutic exercises:	❑Prothesis education/ training:	❑ Gait training:	❑Other:
OT					
❑ Eval & Treat:	❑ ADL Training:	❑Therapeutic exercises:	❑ Cognitive care/deficits:	❑ Lymphatic drainage massage and compression wraps	❑Other:
ST					
❑ Safe swallow techniques	❑ Cognitive Care/deficits:	❑Language intervention therapy:	❑Eval/treat dysphagia/aphagia	❑Visual – motor skill training:	❑Other:
BSW					
❑Referrals to community resources	❑Evaluate social/economic needs	❑Caregiver support	❑Coordinate health care needs	❑Assist with advance directives	❑Other:
Aide (not PCA service; must also have skilled nursing, physical therapy or speech therapy ordered)					
❑Assist with personal hygiene	❑Light exercise	❑Light meal prep	❑Light housekeeping		

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/poor balance ☐ Assist of 1-2 people to ambulate/transfer safely ☐ 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 or with minimal exertion ☐ Recent lower/upper extremity surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation ☐ Medically contraindicated due to immunosuppression/serious risk of infection ☐ Patient is bedbound due to: ______ ☐ Other: ______

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

Print Name: **Pager/Phone:**

Note: Physician Assistants and Nurse Practitioners may perform the encounter visit and complete the form, but the Initial certification and orders must be signed and dated by attending physicians (a MD, DO or DPM).

Confidentiality Notice

The information contained in this facsimile message is confidential information belonging to the sender intended only for the use of the individual or entity named above. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone to arrange for the return of the original document to us.

HIPAA Disclosure

This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. You are prohibited from making any further disclosures of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

For Ohio Valley Home Health:

Referral checked/accepted: ______	Additional information needed: ______
Assigned to: ______	Referral declined d/t: ______
Protocols: ______	