www.BLIZECARE.com
PHONE: (510) 647-8057 FAX: (510) 263-6516

HOME HEALTH REFERRAL

Patient Name	Date of Birth	Sex
		☐ Male ☐ Female

Patient Address			
Patient Phone	**Alternate Patient Phone**	**DPOA/Primary Contact Name**	**DPOA/Primary Contact Phone**
Medicare #	**Medical #**	**Secondary Insurance**	**Social Security #**

Primary Diagnosis

Secondary Diagnosis

Home Health Orders

☐ Skilled Nursing	☐ Social Worker	☐ Wound VAC	☐ Vestibular Rehabilitation
☐ Physical Therapy	☐ Fall Prevention & Balance	☐ Wound Care	☐ Amputee Programs
☐ Occupational Therapy	☐ Cardio/Pulmonary Rehab	☐ Low Vision	☐ Other:
☐ Home Health Aide	☐ Orthopedic Programs	☐ Diabetic Care	
☐ Speech Therapy	☐ Anodyne Therapy	☐ Medication Education	

Check all that Apply

☐ COPD	☐ Poor Endurance	☐ Vertigo
☐ CHF	☐ Frequent Falls	☐ Bed/Chair Confined
☐ DM	☐ Dementia	☐ Immunosuppressed
☐ Difficulty Walking	☐ Dyspnea/SOB	☐ Requires Assist Device

DME

☐ Wheelchair	☐ Walker	☐ Cane	☐ Shower Chair	☐ Oxygen (Attach O2 Sat % & Liter Flow)
☐ Hospital Bed	☐ Rollator	☐ 3-in-1 Commode	☐ Nebulizer (Attach Rx Order)	☐ CPAP/BLPAP (Attach Copy of Sleep Study)

ADDENDUM TO CERTIFICATION: FACE-TO-FACE ENCOUNTER

1. **I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on:**

   _____ (Month) / _____ (Day) / _____ (Year)

2. **The encounter with this patient was in whole, or in part, for the following <u>medical condition</u>, which is the <u>primary reason for home health care</u>:**

   _____

   _____

   _____

3. **I certify that, based on my findings, all services ordered above are medically necessary home health services.**

4. **My clinical findings support the need for the above services <u>because</u>:**

   _____

   _____

5. **Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services *or* infrequently or of short duration when for other reasons) <u>because</u>:**

   _____

   _____

Referring Physician		NPI #
Physician Address	**Physician Phone #**	**Physician Fax #**
Physician Signature		**Date**