Premier Health
Fidelity Health Care

HOME HEALTH REFERRAL FORM

PLEASE COMPLETE BOTH PAGES

Monday-Friday 8am- 5pm
Fax to (937) 208-6401 or toll free (800-717-6401)
Please call (937) 208-6400 or (513) 425-0972 to confirm receipt.

After hours, weekends, and holidays: Please call (937) 208-6400 or (513) 425-0972, leave your name and phone number. The triage nurse will return your call.

Patient Demographics

PATIENT NAME: _____ DOB: ____/____/_____ SSN: _____-_____-_____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

D/C ADDRESS: _____ CITY: _____PHONE #: _____

CONTACT PERSON: _____PHONE #: _____ RELATIONSHIP: _____

Height: _____ Weight: _____ Date physician last saw the patient: _____

Is the physician willing to follow for home care: **YES** or **NO** Start of Care Date: _____

Diagnosis: _____

Allergies: _____

INSURANCE INFORMATION:

Primary: ☐ Medicare ☐ Medicaid ☐ Anthem ☐ Anthem SA
☐ UHC ☐ UHC MC ☐ Other Commercial _____
Group #: _____ WC#_____
Subscriber: _____ Phone: _____
Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Grandparent
☐ Sibling ☐ Friend ☐ Child ☐ Other: _____

Premier Health Advanced Illness Management Program:
☐ Advanced Care Planning ☐ Goals of Care
☐ Symptom Management ☐ Other: _____

THERAPY SERVICES:
☐ Physical Therapy ☐ Occupational Therapy
☐ Speech Therapy Evaluation ☐ Home Safety Assessment
☐ Mobility Training ☐ ADL Training ☐ Exercises
☐ PRECAUTIONS:_____

LABS: ☐ CBC with differential ☐ CPK
☐ BMP ☐ CRP ☐ ESR ☐ Lytes: _____
Trough after: 3rd / 4th / _____ dose / _____date
Other Labs: _____
Report Labs to: _____
(Contact Person Name and Phone Number)

NURSING SERVICES: Physical & Environmental Assessment
☐ Assess for needs ☐ CHF/COPD
☐ Education ☐ Lab: _____
☐ Diabetic Care ☐ Other: _____
☐ Wound Care: _____

SOCIAL WORK SERVICES: Evaluation
☐ Medicaid Follow-up
☐ Community Resources ID & Referral
☐ Other: _____

IV Infusion Drug Name (1): _____
Dose: _____ Frequency: _____
Route: _____Start Date: _____
Stop Date: _____
1st Dose: ☐ No ☐ Yes, include Anaphylaxis Kit

CURRENT IV ACCESS: (Circle One)
☐ PICC Line ☐ Central Line (Single/Double/Triple Lumen)
Date Placed: _____ ☐ Port Needle Size: _____
Accessed: _____ ☐ Midline Length: _____
IV to be placed: ☐ Peripheral IV: will need to be placed
☐ SubQ ☐ IntraMuscular

Physician Signature: _____ Date signed: _____

Physician's office contact: _____ Number: _____-_____-_____

OFFICE USE ONLY

Date Received: _____/_____/_____ Time Taken: _____ Person Taking Referral: _____

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PHYSICIAN CERTIFICATE OF MEDICAL NECESSITY

Face-to-Face Encounter

Patient Name: _____

Encounter Date and Reason for Encounter

I certify that I, or a qualified non-physician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below due to the medical condition also listed below, which relates to the primary reason the patient requires home health services.

Encounter Date: _____ Diagnosis/Reason: _____

Need for Home Health Services

I certify that based on my findings:

a. Home Health Services are medically necessary for this patient (check all that apply):
   - ☐ Nursing
   - ☐ Physical Therapy
   - ☐ Occupational Therapy
   - ☐ Speech Language Pathology
   - ☐ Home Health Aide
   - ☐ Medical Social work

b. This patient is homebound based on the following information:
   _____

   _____

My clinical findings support the need for the above services because:

_____

_____

_____

_____

I certify that this patient is under my care, or has been referred to another physician having professional knowledge of the patient's condition. Services ordered above are needed to treat condition for which patient was hospitalized and/or seen in the office. The composed above information is based on my clinical judgment relating to this patient's medical condition.

Certifying Physician Signature: _____ Date of Signature: _____

Physician Printed Name: _____