HOME HEALTH REFERRAL & FACE-TO-FACE

Complete and Fax to: 904-647-

Please include patient Facesheet, H&P or Last Visit Note, and current Medication List

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

Patient Address: _____

Patient Phone Number: _____ **Referral Date**: _____

PLAN OF CARE ORDERS

FACE-TO-FACE REQUIREMENT

(Must be completed by referring Physician office)

Face to Face Visit Date: _____ Services Medically Necessary: __ SN __ PT __OT __ST __MSW __HHA

Diagnosis and/or reasons for Home Care (Medical conditions) _____

_____

Reason why Patient is Homebound: _____

_____

_____

☐ **Skilled Nursing to evaluate, instruct patient regarding disease process, medication regimen, safety, diet, need for additional services.**

☐ **Patient Informed/Schedule SOC visit with patient** **OR** ☐ **Effective Date** _____

Additional Orders: _____

Goals: To meet patient's medical needs.

"CERTIFYING PHYISICIAN" Signature _____ **Date** _____

(For Allegiant Use Only)

Verbal Order obtained from: _____ **Date** _____

Allegiant Nurse's Signature _____ **Date** _____