Harbors Home Health & Hospice

201 7TH STREET HOQUIAM, WA 98550

HOME HEALTH REFERRAL FORM

Monday – Friday
8 AM – 5PM

Phone Number: (360) 532 – 5454
or (800) 772 – 1319

Return Fax Number:
(360) 533 – 0999

PATIENT NAME: _____ DOB: _____ /_____ / _____

HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

D/C ADDRESS: _____ CITY: _____ ST:_____ ZIP: _____

CONTACT NAME:_____ PHONE #: _____ RELATIONSHIP: _____

DATE PHYSICIAN LAST SAW THE PATIENT: _____ / _____ / _____ PHYSICIAN NPI #: _____

INSURANCE INFORMATION: PRIMARY _____ SECONDARY _____

POLICY NUMBER: _____ GROUP #: _____ SUBSCRIBER: _____

FAX THE FOLLOWING WITH THIS FORM TO: (360) 533 – 0999

☐ Signed Supporting Documents (Within Last 90 Days) ☐ Updated Medication List ☐ POA / POLST FORM (IF APPLICABLE)

PHYSICIAN CERTIFICATE OF MEDICAL NECESSITY

HOME HEALTH ORDERS / FACE – TO – FACE ENCOUNTER

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 due to the medical condition, also listed below, which relates to the primary reason the patient requires home health services.

DIAGNOSIS/REASON: _____ ICD 10 CODE: _____

NEED FOR HOME HEALTH SERVICES

Based on my findings, the following services are medically necessary home health services:

a. Home Health Services (check all that apply)

☐ Skilled Nursing ☐ Occupational Therapy ☐ IV Infusion – Start Date: _____ / _____ / _____

☐ Physical Therapy ☐ Medical Social Worker ☐ Wound Care ☐ Speech Language Pathology

☐ Home Health Aide ☐ Other: _____

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

_____

_____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent Skilled Nursing Care/Physical Therapy and/or Speech Therapy or continues to need Occupational Therapy. The patient is under my care, and I have initiated the establishment of the Plan of Care. The patient will be followed by a physician who will periodically review the Plan of Care.

Patient will be followed in the community by Dr. _____ Phone #: _____

Certifying Physician Signature: _____ Date of Signature: _____ / _____ / _____

Physician Printed Name: _____ NPI #: _____