ADVANCED PROFESSIONAL
HOME HEALTH CARE SERVICES

Home Health Care Referral Form

Intake Fax: 248-487-9985 Phone: 888-707-1773

Patient Name: _____ DOB: _____ M / F

Address: _____

City / Zip: _____ Phone: _____

Insurance Provider: _____ ID # _____

Emerg. Contact/Caregiver: _____ Phone: _____

Diagnosis: 1. _____ 2. _____ 3. _____ 4. _____

Reason for Home Care: _____

Urgency of referral: ☐ Same Day ☐ Within 24 hours ☐ Within 3 days ☐ Within 1 week

Services Desired: ☐ Skilled Nursing ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy
☐ Cardiac Care ☐ Wound Care ☐ Home Health Aide ☐ Social Work

Referring Physician: _____ NPI: _____

Address: _____ City & Zip: _____

Office Phone: _____ Office FAX: _____

PLEASE ATTACH the following Medicare Required Supportive Documentation

- History and physical
- Medication list
- Face to Face (F2F) Encounter documentation: Date of F2F Encounter: ____ / ____ / ____
  (must be within 90 days prior or 30 after the start of homecare)
  - Progress Note, and/or
  - Visit Note, and/or
  - Consultation report

We appreciate your business and look forward to serving your patient with our highly trained staff that combines caring services and technology to treat the person as a whole