Infinity Care Services, Inc.
HOME HEALTH SERVICES

Phone 209-264-0300 - Fax 209-751-1644

PHYSICIAN REFERRAL FORM

PATIENT NAME:		**BIRTHDATE:**	**AGE:**	**SEX:**	**SOCIAL SECURITY:**
ADDRESS:		**CITY:**		**ZIP:**	**PHONE:**
PRIMARY CAREGIVER:	**RELATIONSHIP:**		**PHONE:**		
MEDICARE #:	**MEDICAL #:**		**INSURANCE:**		

CHECK REQUIRED CLINICAL SERVICES

SKILLED NURSING	**MEDICAL SOCIAL WORK**	**PHYSICAL THERAPY**	**OCCUPATIONAL THERAPY**
____ Medication	____ Family Support System	____ Balance	____ Energy Conservation
____ Pain	____ Crisis Intervention	____ Fall risk	____ Sensory Dysfunction
____ Cardiac	____ Counseling Referrals	____ Weakness	____ ADL
____ Diabetes	____ Unsafe Environment	____ Transfers	____ Orthotics
____ Respiratory	____ Stress/Coping/Grief	____ Bed mobility	____ Equipment+ Adaptive Device
____ Wound	____ Alternate Living	____ Wheelchair mobility	____ Other (explain)
Site:	___ In-Home Assistance	___ Ambulation/Gait	
	____ Other (explain)	___ Range of Motion	**SPEECH THERAPY**
____ Other (explain)		____ Strengthening	____ Swallowing
			____ Voice Intelligibility
HOME HEALTH AIDE			____ Hearing
___ Personal Care			____ Language processing
			____ Cognition
			____ Other (explain)

SPECIAL INSTRUCTIONS (PLEASE FAX H&P, RECENT NOTES, APPLICABLE LABS and FACESHEET):

Documentation of Face- to-Face encounter for Medicare patients

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

Medical Condition : The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care(list medical condition):

Medical necessity: I certify that, based on my findings, the following services are medically necessary home health services
(check all that apply): ___ Intermittent Nursing ___ Physical therapy ___ Speech language Pathology

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

Homebound status: Further, I certify 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, and are infrequent or of short duration when for other reasons) <u>because</u>: _____
_____.

REFERRING PHYSICIAN:	**PHONE:**	**FAX:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICIAN'S SIGNATURE:		**DATE:**	

Please note, Start of Care will begin 24 to 48 hours after receipt unless otherwise stated. Thank you for the referral. We will call to confirm receipt of the referral.