



Temporary Help Inc.
Healthcare Staffing Professionals

Home Health Care Fax Referral Form

Phone: 703-533-3060 • Fax: 703-533-3061

GENERAL PATIENT INFORMATION

Name		Social Security:	
Current Address:		City:	State: Zip Code:
Date of Birth: / / 20	Best Contact Phone#:		

INSURANCE INFORMATION

Medicare #	Primary Insurance Name	Primary Insurance Policy #
Other#	Secondary Insurance Name	Secondary Insurance Policy #

ORDERS INFORMATION

- ☐ Skilled Nurse To Evaluate For Home Care Needs
- ☐ Physical Therapy Evaluation & Treatments
- ☐ Occupational Therapy Evaluation & Treatment
- ☐ Speech Therapy Evaluation & Treatments
- ☐ Medical Social Worker Evaluate for Local Resources

Lab Orders: _____
Wound Care Orders: _____
Others: _____

"FACE TO FACE ENCOUNTER" DOCUMENTATION

If Patient's Primary Insurance Is Traditional Medicare, Please Complete This Section:

1. **Primary Diagnosis & Reason for Home Health Care Referral:** _____
2. **Date of Last Face To Face Encounter:** ____ / ____ / ____
(Traditional Medicare patients are required to have a face to face encounter with a MD, APRN or PA within 90days prior to, or 30 days following, the start of home care)
3. **Clinical Findings To Support Need For Home:** _____

4. **REASON PATIENT IS HOMEBOUND:** _____

PHYSICIAN SIGNATURE: _____ DATE ____ / ____ / ____

PRINT NAME: _____ PHONE: _____

*****Please Fax Physicians Referral Form to 703-533-3061*****

1. **PATIENT FACESHEET & PHYSICIANS ORDERS**
2. **HISTORY AND PHYSICAL OR OFFICE NOTES**
3. **INSURANCE CARD COPY (if available)**

For Office Use:

Referral Date: ____ / ____ / ____

Received By: _____

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