

Physician Form

HEMOCARE MARYLAND REFERRAL FORM

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and the following information (or attach demographics / face sheet) and office visit note below.

PATIENT INFORMATION

Patient Name: _____	SSN: _____
Date of Birth: _____ <input type="checkbox"/> M <input type="checkbox"/> F	Address: _____
Phone: _____	City, State, Zip: _____
Emergency Contact Name: _____	Last Flu Vaccine Date: _____
Emergency Contact's Number: _____	Referral Date: _____
Primary Care Physician: _____	Insurance Information: _____
Primary Care Physician Number: _____	<i>(or attach copy)</i>
Office Contact Name: _____	Office Contact Number: _____

DIAGNOSIS / MEDICAL CONDITION: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

SKILLED SERVICES / INTERVENTIONS: *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

Skilled Nursing for: _____ Occupational Therapy: _____

Physical Therapy for: _____ Social Work: _____

Speech Therapy for: _____ Home Health Aide: _____

ADDITIONAL ORDERS: _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.

CLINICAL FINDINGS: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*

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