HOMECARE MARYLAND
A LIFEBRIDGE HEALTH PARTNER

Anne Marie Ferrara
Home Health Liaison
Phone: (410) 598-4039
Fax: (877) 200-5751

HOME HEALTH REFERRAL FORM

Patient Name: _____ DOB: _____
Provider: _____ Provider Phone: _____
Last Appt: _____ Provider Fax: _____

Primary Diagnosis for Home Care:_____

_____

Comorbidities: _____ _____

_____

REASON FOR REFERRAL:

☐ Medication Management/Education
☐ Disease Management/Education
☐ Diabetes management/Education
☐ Wound Care
☐ Respiratory/Lung Disease Management
☐ Home Therapeutic Exercise Program
☐ Home Safety Eval

DISCIPLINES NEEDED:

☐ SN ☐ ST
☐ PT ☐ HHA
☐ OT ☐ MSW

Notify provider of vital signs outside of the following patient specific parameters:

☐ O2 Saturation < _____
☐ Systolic BP > _____ or < _____
☐ Diastolic BP > _____ or < _____
☐ HR > _____ or < _____
☐ Respirations > _____ or < _____
☐ Temperature> _____ or < _____

PLEASE FAX FORM TO 1-877-200-5751 WITH THE FOLLOWING:

- Any specified orders (i.e. wound care)
- Demographics and Insurance Information
- Recent notes/ History & Physical INCLUDING Face to Face Encounter Document
  ***This must be documentation of an in person encounter within 90 days of the requested Homecare admission date & directly related to the primary reason for homecare. Please note Telephone only encounters cannot be accepted.

Provider Signature: _____ Date:_____