

PHYSICIAN REFERRAL FORM

BESTCARE CENTRAL COAST HOME HEALTH AGENCY

277 South Street, Suite W – San Luis Obispo, CA 93401 • Phone (805) 782-8600 Fax (805) 782-8612
A Service of Wilshire Foundation

REFERRAL REQUESTED: <input type="checkbox"/> WITHIN 48 HOURS <input type="checkbox"/> URGENT <input type="checkbox"/> OTHER:		
Patient Name:	D.O.B.:	SS#:
Address:	Phone:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City, State, Zip		Language other than English:
Emergency Contact Person:	Emergency Phone:	Lives Alone: <input type="checkbox"/> Y <input type="checkbox"/> N Caregiver: <input type="checkbox"/> Y <input type="checkbox"/> N
DPOA:	DPOA Phone:	
Physician:	CA License #	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
Physician Phone:		UPIN #:
Insurance: HIN#: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other:		
DIAGNOSIS:		ALLERGIES

HOME SAFETY ASSESSMENT REFERRAL <input type="checkbox"/> Y <input type="checkbox"/> N
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ORDERS FOR DISCIPLINES AND TREATMENT – Check indication for each discipline ordered below:

<input type="checkbox"/> SKILLED NURSING Eval & Instruct for:	<input type="checkbox"/> Pain <input type="checkbox"/> Medication <input type="checkbox"/> Elimination <input type="checkbox"/> Nutrition/Therapeutic Diet <input type="checkbox"/> Terminal Care	<input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Diabetic Management <input type="checkbox"/> Mental Health Management <input type="checkbox"/> Other: (specify) _____	<input type="checkbox"/> Wound/Skin Type: _____ Site: _____ Order: _____
<input type="checkbox"/> PHYSICAL THERAPY Eval & Instruct for:	<input type="checkbox"/> Bed Mobility <input type="checkbox"/> Weakness <input type="checkbox"/> Transfers <input type="checkbox"/> Ambulation/Gait	<input type="checkbox"/> Balance <input type="checkbox"/> Fall Risk <input type="checkbox"/> Equipment Needs <input type="checkbox"/> Wheelchair Mobility	<input type="checkbox"/> Range of Motion <input type="checkbox"/> Home Safety <input type="checkbox"/> Other: (specify) _____
<input type="checkbox"/> SPEECH THERAPY Eval & Instruct for:	<input type="checkbox"/> Speech/Voice Intelligibility <input type="checkbox"/> Alternate Communication Needs <input type="checkbox"/> Swallowing	<input type="checkbox"/> Hearing <input type="checkbox"/> Language Processing Comprehension/Expression/Cognition _____	<input type="checkbox"/> Other: (specify) _____

MUST HAVE SKILLED NURSING, PT OR ST ON THE CASE TO ORDER THE SERVICES BELOW

<input type="checkbox"/> OCCUPATIONAL THERAPY Eval & Instruct for:	<input type="checkbox"/> ADLs/Self Care <input type="checkbox"/> UE Impairment <input type="checkbox"/> Perceptual Motor/Eye-Hand Coordination <input type="checkbox"/> Cognitive/Emotional Impairment	<input type="checkbox"/> Energy Conservation <input type="checkbox"/> Sensory Dysfunction-Visual field neglect/ Pain/Numbness/Neglect/Hemiparesis <input type="checkbox"/> Orthotics/Splinting-Body Mechanics/ Joint Protection/Positioning	<input type="checkbox"/> Kitchen/Bathroom Safety <input type="checkbox"/> Other: (specify) _____
<input type="checkbox"/> MEDICAL SOCIAL WORKER Eval & Instruct for:	<input type="checkbox"/> Behavioral Disturbance <input type="checkbox"/> Alternate Living <input type="checkbox"/> Financial Problems <input type="checkbox"/> Inadequate Food/Supplies <input type="checkbox"/> Terminal Care	<input type="checkbox"/> Family Support System <input type="checkbox"/> Counseling Referrals <input type="checkbox"/> Stress/Coping/Grief <input type="checkbox"/> Transportation <input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Protective Services <input type="checkbox"/> Unsafe Environment <input type="checkbox"/> In Home Assistance <input type="checkbox"/> Other: (specify) _____

COMMENTS/REASON FOR REFERRAL:

Medication List: Attached Patient competent to sign consents DPOA/Conservator: _____

Referral to home health discussed with Patient/Caregiver **Physician office contact:** _____

Note: Upon receipt of referral, BestCare Staff will contact the Patient/Caregiver to notify them of referral and schedule time of visit.

Verbal Order by: _____ **or MD Signature:** _____ **DATE:** _____

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SEE REVERSE FOR HOME HEALTH REFERRAL GUIDELINES
Please call BestCare at (805) 782-8600 to notify intake office of incoming faxed referral.
www.bestcarehomehealth.org

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PHYSICIAN GUIDELINES FOR MAKING HOME HEALTH REFERRALS

Guidelines for Coverage of Service

- The patient is homebound due to medical reasons:
- The patient requires the skilled services of a:
 - Registered Nurse
 - Physical Therapist
 - Speech Language Pathologist/Therapist
- The patient and/or patient's caregiver is willing and able to participate in the plan of care.
- Service(s) cannot be exclusively for the purpose of phlebotomy.
- Skilled services are part-time and intermittent.

Agency Requirements

- The patient's residence must be physically adequate for proper patient care and safe for the Home Care staff.

Physician Responsibilities

- Sign Orders:
Home Health Certification and Plan of Care (HCFA #485): a computer generated document incorporating original orders and clinical assessment. It is required to meet regulatory requirements and to be reimbursed for services. Physician signature is required on this form within 30 days of start of care.

Change in Plan of Care: is a document that contains previously obtained verbal orders for changes in care. Physician signature is required on this form within 30 days of verbal order.

- Provide alternative physician coverage when not available.