Preferred
HOME CARE OF NEW YORK

FAX REFERRAL TO: 718.705.6922
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Happier at home.™

HOME CARE REFERRAL FORM

☐ General Home Care ☐ PWDD ☐ Hospice ☐ Long Term Care ☐ CDPAP

Patient Information

Sex ☐ Male ☐ Female

Name Last First

Address

City State Zip

Social Security D.O.B / /

Phone Cell

Primary Language

Insurance Information

Medicare # Medicaid #

Commercial Insurance

Subscriber

Policy # Group #

Referral Source Contact

Name Last First

Organization

Phone Email

Emergency Contact 2

Name Last First

Relationship

Phone Cell

Emergency Contact 2

Name Last First

Relationship

Phone Cell

Home Care Orders

Requested Services ☐ RN ☐ PT ☐ OT ☐ SLP ☐ HHA ☐ SW

Home Care Diagnosis

Gait Ambulatory Status ☐ Bedbound ☐ Assistive Device ☐ Unassisted

Wound Care Orders ☐ Orders attached

Medications Dose, Frequency and route. ☐ List attached

Physician Signing Home Care

Physician Name Phone Fax

Address City State Zip

NPI# License Office Contact

Signature Date

Face-To-Face Encounter Certification

Patient Name

I Certify that a face-to-face encounter was performed on the above named patient on / / by

Who is a ☐ Medicare enrolled physician or ☐ a permissible non-physician practitioner. The clinical reason for the encounter was:

The Patient's clinical, condition, as observed during the encounter, supports the patient's homebound status as follows :

PLEASE ATTACH CORRESPONDING PROGRESS NOTES. FOR PWDD PLEASE INCLUDE ISP EVALUATION