KŪRE HOME HEALTH
YOUR HEALTH | OUR MISSION

PLEASE FAX THE
COMPLETED FORM TO
Office Fax (559) 314-6123
Office Tel (559) 207-3825

Information to be Faxed with Referral:
Demographics/Insurance Info: _____ Medication List _____ H&P _____ Office Note _____

Patient Information:
Name: _____ DOB: ____/____/____ Male ____ Female ____
Phone:_____
Address (where services provided) Street: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____
Referred Physician: _____ NPI: _____Phone #: _____
Primary Diagnosis: _____
Secondary Diagnosis: _____
Insurance Info: _____
Allergies: _____ Next scheduled visit: _____
Service(s) Needed:
Skilled Nursing: _____

____Medication Compliance ____ Wound Care
____ Diabetic Education ____ GT Feeding
____ Ostomy or Foley Care

Occupational Therapy: _____ Physical Therapy: _____
___Transfer ____ Gait/Balance
____ Assist ADL's/IADL's ____ Bed Mobility
____ PT/PCG Training Decidses (W/C, Walker, Cane)

Speech Therapy: _____ Social Worker: _____ Home Health Aide: _____
____ Speech/Swallowing ____ Community Resources ____ Assist w/ADL's

Referral Contact Person & Phone #: _____

"Face to Face Encounter" (F2F) Documentation for Medicare Patients

I, or as nurse practitioner or physician's assistant working with me, had a face-to-face encounter with this patient that addressed the primary reason for home health care.

Date of the F2F visit ____/____/____
Reason for home health care: _____
Clinical Findings to support the need for home health services: _____
_____
Patient is homebound because: _____
_____
Physician Signature: _____ Date: ____/____/____
Physician Name Printed: _____