FAX

QUALITY FIRST HOME CARE
KEEPING FAMILIES TOGETHER AT HOME

COLUMBIA
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931.762.6979

From:_____ Pages:_____ Date:_____

Home Health Referral Checklist

PLEASE ATTACH THE ITEMS LISTED BELOW

Patient Information

- ☐ **Basic demographics**
  - DOB
  - SS#
  - Current address (no PO Box)
  - All phone and alternate phone #'s
- ☐ **Emergency contact**
- ☐ **Pharmacy**
- ☐ **Insurance information**

Clincial Documentation

- ☐ **List of ALL diagnoses**
  - symptoms codes ("R codes") are no longer accepted by Medicare for admission
  - be as specific as possible
- ☐ **Updated medications listing**
- ☐ **Last office note (Face to Face)**
  - office visit must be within the last 90 days
  - must be signed and dated by the provider (e-signature is acceptable).
- ☐ **Order for Home Health**
  - can be included in office note or on separate script pad
    - must be signed by an MD
    - must include statement of the need for home health services (include discipline needed such as SN, PT, etc.)
- ☐ **Any other pertinent clinical information**

  notes supporting need for home health services and previous office visit notes as needed