



SUNSHINE HOME HEALTH CARE, INC.

4637 Chabot Dr. Suite 240, Pleasanton, CA 94588
Phone: (925) 469-1000 Fax: (925) 469-1001

Compassion. Reliability. Results.

REFERRAL FORM - HOME HEALTH SERVICES

PATIENT INFORMATION:

Name: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: _____ ER Contact: _____ ER #: _____

PAYOR INFORMATION:

Primary Insurance: _____ Policy No.: _____

Secondary Insurance: _____ Policy No.: _____

SERVICES REQUESTED:

- Skilled Nursing
- Speech Therapy
- Medical Social Worker
- Physical Therapy
- Occupational Therapy

DIAGNOSIS: _____

SURGICAL PROCEDURE: _____ Date: _____

FACE-TO-FACE ENCOUNTER REQUIREMENT

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on, _____ (date)

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health: _____

Provide a summary of clinical findings that support the patient's eligibility for home health services: _____

Further, I certify that my clinical findings support that this patient is homebound because: _____

Physician Printed Name: _____ NPI: _____

Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

This message is intended for the use of those to whom it is addressed and may contain information, which is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agency responsible for delivering the message, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us. Thank You.