SUNSHINE HOME HEALTH CARE, INC.

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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: _____