PHYSICIAN PATIENT REFERRAL
Please fill out as much information as possible

CareLink Home Health, LLC
South Barrington

PATIENT REFERRAL

For Evaluation and Treatment

Patient Name: _____

Address: _____

Date of Birth: _____ Tel. No.: _____ Cell No.: _____

Date of Discharge _____

(Note: Please fax patient D/C Instructions, including H & P, Med List, Consultation Report, Physician's Order for Home Care)

Medicare No.: _____

Private Insurance: _____ Policy No.: _____

Emergency Contact _____

Name: _____ Tel. No. _____

Diagnosis: _____

_____

Services Requested:

[ ] Skilled Nursing
[ ] Home Health Aide
[ ] Physical Therapy
[ ] Laboratory Order _____
[ ] Occupational Therapy
[ ] Speech Therapy
[ ] Medical Social Worker
[ ] Others _____

Primary Physician: _____ UPIN # _____

Please Fax to 847-426-0301 or E-fax to 847-620-0616

33 W. Higgins Road, South Barrington, IL 60010 : Office # 847-426-0300 : 24Hrs Hotline # 847-987-5090

CareLink Home Health, LLC

33 W Higgins Rd., Suite 5020, South Barrington, IL 60110
Office: (847) 426-0300 Fax: (847) 426-0301

PATIENT NAME: _____ **DATE**: _____
(Last, First, Middle Initial)

*Mark all applicable with an "X". Circle appropriate item(s) separated by "/ "

ELIGIBLE ENCOUNTERS

- □ Institutional Provider conducted the face-to-face encounter.
- □ Home health Plan of Care Certifying Physician: _____
  - □ Conducted a face-to-face encounter 90 days prior to Start of Care.
  - □ Will have a face-to-face encounter within 30 days after Start of Care.
    SOC Date: _____ Face-to-face encounter due by: _____

PHYSICIAN ATTESTATION

To be filled out by physician who conducted face-to-face encounter

- I certify that this patient is under my care and that I, 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: _____.
- The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:

  _____
  _____
- My clinical findings support the need for the above services because:

  _____
  _____
  _____
  _____

□ I certify that, based on my findings, the following home health services are medically necessary for this patient:

☐SN	☐PT	☐OT
☐Aide	☐ST	☐MSW
☐MSW	☐Other (specify):	

- I certify that my clinical findings support that this patient is homebound because:
  (*i.e.,* needs assistance for all activities, residual weakness, requires max assistance/taxing effort to leave home, confusion/unsafe to go out of home alone, severe SOB/SOB upon exertion, unable to safely leave home unassisted and/or any other clinical factors that affect homebound status.)

  _____
  _____
  _____
  _____
  _____

_____ _____
Physician Signature ***Date*** *(mm/dd/yy)*