Superb HOME CARE

12101 Joseph Campau St.
Suite 2A
Hamtramck, MI 48212
P: (313) 366-9800
F: (313) 366-2888
Email: superbhha@gmail.com

Home Care Referral Form/Face to Face Encounter

Demographic Info

Patient Name: _____
Address: _____
_____
Phone: _____
Date of Birth: _____
Sex: M or F

Insurance Info

Primary Ins: _____
ID#: _____
Policy #: _____
Group: _____
Medicare #: _____
Medicaid #: _____

Physician Signing Orders

Name: _____
Phone: _____
Fax: _____

Home Care Diagnosis: *(fax pertinent history, last physician note and medication sheet if available)*

_____
_____
_____

Reason for Referral/Special Orders: _____

_____

Skilled Nursing

☐ Eval and Assess for Needs
(i.e.: Safety, Med / Diet Teaching, Home Health Aide Needs, Disease Management/Monitoring, Medical Social work etc.)

☐ Skilled Nurse
☐ Home Health Aide/Caregiver
☐ Wound/Ostomy Consult
Current treatment: _____
_____

Therapy Services

☐ PT Eval and Treat for Needs
(i.e.: Gait Training, Fall Prevention, Therapeutic Exercise Program, and Strengthening)
☐ Post Surgical Joint Therapy
☐ ST Eval and Treat for Needs
☐ OT Eval and Treat for Needs

Complete for Medicare/Traditional Medicaid Patients

☐ Homebound (for Medicare patients only). Patient is homebound due to (limitations/restrictions):

Please FAX this form to (313) 366-2888

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) _____

Physician Signature (Required for Medicare Patients): _____

Signature of Person Completing Form _____ Date _____

Thank You For Your Referral!