Preferred Care
HOME HEALTH SERVICES

PCHHS.COM

Home Health Referral Form

FT. MYERS FAX: (239) 425-2671 **MIAMI FAX: (305) 275-7058**
NAPLES FAX: (239) 262-2401

DEMOGRAPHICS

PATIENT NAME: ______________________ DOB: __________

ADDRESS: ______________________

CITY/FL/ZIP: ______________________ PHONE: __________

SOCIAL SECURITY #: ______________________ MEDICARE #: __________

FACE-TO-FACE ENCOUNTER

1. DATE OF FACE-TO-FACE ENCOUNTER: ______________________

2. DIAGNOSIS/MEDICAL CONDITION(S): ______________________

3. SERVICES REQUESTED: ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA ☐ PSYCH

(*See reverse for acceptable face-to-face documentation.)

4. CLINICAL FINDINGS TO **SUPPORT SERVICES**: ______________________

5. CLINICAL FINDINGS TO SUPPORT **HOMEBOUND STATUS**: ______________________

SPECIFIC ORDERS (ie. Labs, wound care, etc.): ______________________

Physician's Full Name *(print)* ______________________

Physician's Signature *(no stamps)* ______________________ **Date:** __________

Contact at Physician's Office (*print*) ______________________ **Phone:** __________

Please attach **Patient's Medical History & Last Office Visit Note**

Thank you for your referral