Guardian Angel
Home Health & Hospice Care

# REFERRAL REQUEST FORM

**GUARDIAN ANGEL HOME HEALTH & HOSPICE CARE**

1715 Northfield Dr., Rochester Hills, MI 48309

| HOMECARE | PHONE: 248-293-2400 | FAX: 248-293-2401 |
|---|---|---|
| HOSPICE | PHONE: 248-293-2441 | FAX: 248-852-2175 |


DATE:________________

| CONCIERGE NAME: | |
|---|---|
| PHONE : | |
| EMAIL: | |

## PATIENT INFORMATION:

| NAME: | | D.O.B. | | |
|---|---|---|---|---|
| ADDRESS: | | PHONE: | | |
| CITY/STATE/ZIP: | | EMEG. CONTACT: | | |
| **PCP:** | | **PHONE/FAX:** | | |
| INSURANCE: | | POLICY NO.: | | |
| OTHER INS.: | | POLICY NO.: | | |
| DIAGNOSES: | | | | |

| SERVICES: | ☐ SN | ☐ PT | ☐ OT | ☐ SLP | ☐ MSW | ☐ HHA | ☐ HOSPICE |
|---|---|---|---|---|---|---|---|

☑ *Check all that apply.*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Diabetes | | COPD | | Alzheimer's | | HIV/AIDS | | Mental Health |
| | HTN/CHF | | CVA | | ALS | | Would/Lesions | | Fall Prevention |
| | CKD | | Dementia | | Vision Problem | | Pressure Ulcers | | Muscular Weakness |
| | Asthma | | Parkinson's | | Cancer | | Stasis Ulcers | | Gait Abnormality |
| | Other: | | | | | | DME Request: | | |

## FACE-TO-FACE: *Must be completed by PCP Physician or Physician Representative only. Thank you.*

| **F2F ENCOUNTER DATE:** ________/________/________ | The F2F encounter was in whole, or in part, for the following condition(s) which is the primary reason for the home health *(conditions necessitating home health)*: |
|---|---|
| **CLINICAL FINDINGS:** | My clinical findings *(as identified in the F2F encounter)* support the need for skilled nursing or therapy services for the following reasons: |

☐ Supportive device *(describe)*:

☐ Assistance needed from another person *(explain)*:

☐ Leaving home is medically contraindicated *(explain)*:

☐ The patient requires considerable taxing effort *(explain)*:

☐ Other Concerns:

**Community Physician Certification Statement:** Based on the above findings, I certify that the patient is homebound and needs intermittent SN, PT, OT or SLP. The patient is under my care, and I will periodically review the plan of care.

**Inpatient Physician Certification Statement:** Based on the above findings, I certify that this patient is homebound and needs intermitting SN, PT, OT or SLP. The patient is under my care, and I have initiated the home health plan of care. The patient is followed by a physician who will periodically review the plan-of-care.

## * PHYSICIAN AUTHORIZATION *

** By signing below, the physician authorizes orders and validates the F2F encounter with the patient. Please provide doctor orders.*

SIGN HERE ☞ **PHYSICIAN (MD) SIGNATURE:**____________________________Date:____________

**Physician Name (print):** ________________________________

(**Please include:** Signed Referral, Doctor's Order, Demographics, and F2F)
THANK YOU

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