HOME HEALTH REFERRAL FORM

Guardian Angel Home Health Care & Hospice

Guardian Angel Home Health Care, Inc.

CORPORATE INTAKE
Phone: 888.762.6435 | Fax: 844.305.3812
www.guardianangel.net

DATE:	
CONTACT:	
PHONE:	
EMAIL:	

PATIENT INFORMATION:

Patient Name:		**D.O.B.**	
ADDRESS:		PHONE:	
CITY/STATE/ZIP:		EMEG. CONTACT:	
Primary Doctor:		PHONE/FAX:	
INSURANCE:		POLICY NO.:	
OTHER INS.:		POLICY NO.:	
***DIAGNOSES:**			

HOME HEALTH NEEDED: ☐ SN ☐ PT ☐ OT ☐ SP ☐ MSW ☐ HHA

☑ *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:				

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

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):

F2F ENCOUNTER DATE:	
COMMENTS:	

➞ 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 is the patient is homebound and needs intermittent SN, PT, OT or ST. 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 ST. 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.*

SIGN HERE ☞ **PHYSICIAN (MD) SIGNATURE:** _____ Date:_____

Physician Name (print): _____

PLEASE FAX TO CENTRAL INTAKE: 844.305.3812

(**Please include** signed referral/doctor order, demographics. latest encounter notes). *Thank you kindly.*