PATIENT CARE REFERRAL FORM

NAVITAS
HOME HEALTH CARE

Navitas Home Health Care

Please *Complete and fax the following information* to (559)383-2003
Include: Demographics Copy of Insurance cards, H&P Most Recent MD Visit note that triggered the Home Health Referral

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____

Address: _____ Alternate Phone: _____

Insurance Type: _____ Insurance #: _____

Emergency Contact: _____ Allergies: _____

PATIENT WILL BE OPENED IN 48 HOURS UNLESS A START OF CARE IS SPECIFIED _____

PROVIDER

Name: _____ Date: _____

NPI: _____ Phone: _____

Fax: _____ Sent By: _____

Requested Services (Check all that apply)

SN EVALUATION FOR	PT EVALUATION FOR	OT EVALUATION FOR	ADDITIONAL
___ Skilled Nursing	___ Gait/Balance	___ Train in ADL's	___ ST Eval: Speech/Swallowing
___ Medication Compliance	___ Transfers	___ Energy Conservation	___ CHHA: Personal Care and Hygiene
___ Wound Care	___ Bed Mobility		___ Other: Describe
___ Diabetic Care	___ Safety Eval		
___ Ostomy/Foley Care	___ PT/PCG Training Devices (WC, Walker, etc.)		
___ G-Tube Feedings			
___ IV Therapy			
___ Disease Management			

FACE-to FACE Encounter: Date: _____
Medical Condition/Reason for Home Health: _____
Clinical Findings supporting need for Home Health: _____
Clinical Findings Supporting homebound Status: _____

I certify that this patient is under my care and that I (or Nurse Practitioner/Physician Assistant working under me) have had a Face-To-Face encounter with this patient as noted above.

PHYSICIAN SIGNATURE: _____ Date: _____