



HOME HEALTH & PALLIATIVE CARE REFERRAL FORM

CENTRAL COAST VNA & HOSPICE
PATIENT CARE PLANNING DEPARTMENT

FAX 831-648-4238

PHONE-831-375-9882

REFERRAL DATE _____ REQUESTED START DATE _____

PATIENT INFORMATION:

NAME _____ DOB _____

PRIMARY DIAGNOSES _____

SKILLED SERVICES RN PT OT ST MSW HHA

SPECIALTY PROGRAMS: PALLIATIVE CARE CARDIAC WOUND CARE DIABETIC CARE REHAB SPECIALTIES

ORDERS: _____

PHYSICIAN RESPONSIBILITIES

1. SIGN ORDERS: The Home Health Certification and Plan of Care (HCFA 485) required by regulation and for reimbursement. Physician signature is required on this form within 30 days of start of care home health services, and indicates physician's agreement that patient meets regulatory program criteria (homebound, skilled need, medical necessity).
2. CHANGE IN PLAN OF CARE: Additional orders by physician require signature within 30 days of order.
3. PHYSICIAN COVERAGE: When not available, please provide alternate physician coverage.
4. DRUG REGIMEN REVIEW: Required by CMS within 24 hours of start of care, along with initial agreement to clinician plan of care

REFERRING MD NAME (PRINT) _____

MD SIGNATURE _____

PHONE _____ FAX _____

Please identify if physician following for home care is different than the referring physician:

The physician to follow for home care was notified of home care referral: Y ___ N ___

PLEASE FAX THE FOLLOWING TO 831-648-4238:

1. PATIENT FACESHEET
2. HISTORY AND PHYSICAL OR OFFICE NOTES
3. INSURANCE CARD COPY if available, or INSURANCE INFORMATION
4. FOR PALLIATIVE CARE, PLEASE INCLUDE DOCUMENTATION OF TERMINAL DIAGNOSIS AND EXPECTED PROGNOSIS

PLEASE NOTE: RECEIPT OF THIS FORM DOES NOT GUARANTEE ACCEPTANCE OF REFERRAL