HOME HEALTH REFERRAL FORM

crossroads HEALTHCARE AT HOME
an Impact company

Vallejo Branch
127 Hospital drive, Vallejo, CA 94589
Tel: 707-554-4003
Fax: 707-554-4043

Please complete all sections below and include a copy of last progress/visit note, medication list and past medical history

Patient Demographics

Patient Name: *(Last Name, First):*

_____

Patient Date of Birth:

_____/_____/_____

Patient Address:

_____

_____

Patient Telephone:

(_____) _____-_____

Patient's Sex:

☐ Male ☐ Female

Patient SSN: _____ - _____ - _____

Patient Allergies: _____

Primary Caregiver / Emergency Contact or Durable Power of Attorney:

Name: _____ Tel: (_____) _____-_____

Primary Payer Information

☐ **Medicare**: _____

☐ **Medi-Cal**: _____

☐ **HMO/Commercial Insurance**

Health Plan: _____

Policy #: _____

Home Health Orders

Evaluate and if appropriate, admit and treat under Home Health

Please select the discipline(s) the patient should be evaluated for:

☐ **Skilled Nursing** ☐ **Occupational Therapy** ☐ **Medical Social Worker**

☐ **Physical Therapy** ☐ **Speech Therapy** ☐ **Home Health Aide**

☐ **Palliative Care - Evaluate and admit, if appropriate**

Diagnosis

Primary Diagnosis or Condition for which patient is being referred to service(s):

_____

_____

Referring Provider Signature

Referring Provider Signature: _____ Date: _____/_____ /_____

NP or PA signatures must be accompanied by a Physician Signature

Print Name of Referring Provider: _____ (indicate MD, DPM, DO)

Tel: (_____) _____-_____ Fax: (_____) _____-_____

FAX COMPLETED FORM TO: 415-682-2112 OR EMAIL TO: eFAX@CROSSROADSHH.COM

By referring this patient to Home Health, you are certifying that this patient is homebound and agree to follow the patient's plan of care and sign subsequent orders. You may use this form or send copies of the information above. If you have any questions, please feel free to call us.