los robles
HEALTHCARE AT HOME
an Impact company

Physician's Referral Form

Home Health, Bridge or Hospice Services

phone: (310) 782-1177 · fax: (310) 782-1171 · email: intakelr@losrobleshc.org

Patient Name: _____ DOB: _____
SSN/Medicare #: _____ Primary Ins: _____
Encounter Date: _____ Primary DX: _____
Patient Location: _____
PCP: _____

Please Attach- Demographics Sheet, H&P/Clinic Note(s), Current Medication List, Recent Labs

HOME HEALTH:
Evaluation and Treatment for (please circle all that apply):

SN PT OT ST AIDE MSW

Wound Care: _____
Lab: _____
Aide Services: _____
Respiratory: _____
Other: _____

◯Chronic Disease Management/ Vital Sign Monitoring ◯New Medication Teaching/ Monitoring
◯IV Medication Administration/ Treatment ◯Lymphedema Treatment
◯Bedside Swallow/ Dysphagia Treatment ◯Balance/ Strengthen/ Range of Motion
◯Adaptive Equipment Training ◯Stoma Care/ Training

FACE TO FACE ENCOUNTER- Date: _____

◯My clinical findings support the need for skilled services due to the following medical condition(s):
_____
◯Further, I certify that my clinical findings from my encounter support that the patient is homebound:
_____

BRIDGE PROGRAM:
Bridge DX: _____ ◯Los Robles Bridge to Eval/Admit

◯In consultation with the patient, I will remain the attending physician, will sign all physician orders, and remain in open communication with the Los Robles Bridge Team.

HOSPICE SERVICES:
Hospice DX: _____ ◯Los Robles Hospice to Eval/Admit

◯In consultation with the patient, I prefer to remain the attending physician and will sign all physician orders and remain in open communication with the Los Robles Hospice Team.
◯In consultation with the patient, I prefer to remain the attending physician with the Hospice Medical Director to provide symptom management.
◯In consultation with the patient, I prefer to relinquish my role as the attending physician. Pursuant to consultation with the patient, the Hospice Medical Director will take over as the attending physician.

Referring Physician Signature: _____ Date:_____
Print MD Name: _____ Title: _____