ORDER FOR HOME CARE SERVICES

residential

home health | palliative | hospice

Fax Number: (866)903-4000 **Intake Phone: (866)902-4000**
residentialhomehealth.com Available every day of the year 24/7

Please include patient progress note for face-to-face encounter date.

Patient Information

☐ See Attached Demographic Sheet

Patient Name: _____ Patient Date of Birth: ____ /____ /____

Patient Address: Street _____

City: _____ State: _____ Zip: _____ County: _____

Patient Phone(s): _____

Patient Insurance Policies & Numbers: _____

_____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Contact Email: _____

Physician Ordering Home Health: _____

Physician Phone Number: _____

DATE OF FACE-TO-FACE VISIT: ____ /____ /_____ **Must be within 90 days before or 30 days after Start of Care**

MEDICAL CONDITION: _____

Residential Home Health is to provide the following medically necessary services:
(Please check the appropriate box and explain the reason why if RN, PT or ST. Reason must be filled out for face-to-face).

☐ RN ☐ PT ☐ ST reason for: _____

_____

☐ HHA ☐ MSW ☐ OT *(OT, MSW or HHA cannot be ordered without PT or RN)*

HOMEBOUND STATUS - PATIENT MUST MEET BOTH HOMEBOUND CRITERIA.

Homebound Criteria 1 : _____
(Aid of a person or device or unable to leave home due to medical condition)

Homebound Criteria 2 : _____
(Why the patient is unable to leave the home)

RESIDENTIAL HOME HEALTH PROGRAMS NEEDED:

- ☐ Joint Replacement Therapy (RN, PT, OT)
- ☐ CHAMP (CHF and COPD Management) (RN)
- ☐ StepWise (RN, PT, OT)
- ☐ MindCare (RN, PT, OT, ST, MSW)
- ☐ LSVT Big - Parkinson's (PT, OT)
- ☐ LSVT Loud - Parkinson's (ST)
- ☐ Telehealth Program (RN, PT, OT)
- ☐ Comfort Path

OTHER PROGRAMS NEEDED:

- ☐ Residential Hospice
- ☐ Palliative NP Consult (Part B)
- ☐ Other Services Needed:

_____

_____

Physician Signature : _____ **Date:** ____ /____ /____