Fax Referral Sheet

Physician's Choice Homecare

"Quality Is Our # 1 Priority"

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Date: _____

Referring Physician: _____ Physician NPI: _____

Physician Address: _____ Phone: _____

Patient's Name: _____ DOB: _____

Address: _____

Telephone: _____ SSN#:_____

Emergency Contact: _____

Primary Diagnosis: _____

Medicare #:_____ Medicaid #:_____

Ins Provider: _____ Policy #:_____

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply) (**Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care)**:

☐Skilled Nursing ☐Occupational Therapy ☐Home Health Aide
☐Physical Therapy ☐Speech Therapy ☐Other: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred) (MM/DD/YYYY):_____

The patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care or will be transferred to the care of his/her physician and I have authorized home health services.

Referring Physician/Signature: _____ Date: _____