www.prostarscare.com
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HOME HEALTH REFERRAL ORDER

Patient Name		**Date of Birth**	**Sex:** ☐ **Male** ☐ **Female**
Patient Address			
Patient Phone Number	Patient Cell Phone	Primary Care Contact #	**Primary Care Contact Name/DPOA**
Medicare #	Medical #	Secondary Insurance	Social Security #
Primary Diagnosis			
Secondary Diagnosis			
Home Health Orders ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Social Worker ☐ Speech Therapy ☐ Home Health Aide			
Frequency: Instructions:			

I certify that this patient base on my clinical findings is homebound and leaving home requires a considerable and taxing effort. I also certify that this patient had face- to- face encounter requirements that was performed on _____ by a physician or Non-Physician Practitioners working within my medical practice arena. The encounter with this patient was in whole, or in part, for the following medical condition, which is the primary reason for home health services: _____
_____

I further certify that this patient is under my care and I authorize the initial plan of care which will be further develop by me or Dr._____who is overseeing the home health services. I certify that, based on my findings, all services ordered above are medically necessary home health services. My clinical findings support the need for the above services because: _____
_____

Admit patient to Pro-Stars Health Care for Home Health Services from _____ through_____
SN to assess, evaluate, and instruct patient on disease process, knowledge deficit of medication, safety and diet.

Discharge patient from home health services due to:
☐ Patient/Physician Request ☐ Patient moved to Healthcare Facility ☐ Patient moved from service area
☐ Patient is non-compliant ☐ All goals have been met ☐ Patient Opted for HMO
Goals: To meet patient's Medical needs. Patient Informed: ☐ Yes ☐ No

Referring Physician Name		NPI:
Physician Address	Physician Phone #	Physician Fax #
Physician Signature		Date Time