Care of Excellence
HOME HEALTH

QUICK FAX REFERRAL/ORDER FORM

PHONE: 817-842-4263 | FAX: 817-842-4264

OFFICE HOURS | MONDAY - FRIDAY 9:00 AM - 4:00 PM

AVAILABLE 24/7 AFTER HOURS & WEEKENDS, PLEASE CALL TO SPEAK TO THE ON-CALL NURSE

751 US Highway 287 North | Suite # 104 | Mansfield, TX 76063

PATIENT INFORMATION

PATIENT NAME:

PRIMARY DX:

SECONDARY DX:

SKIP BELOW IF DEMOGRAPHICS SHEET IS ATTACHED

STREET/APT:

CITY/STATE/ZIP:

PHONE:

SOCIAL SECURITY #:

GENDER: MALE / FEMALE DOB:

MEDICAL POA:

EMERGENCY CONTACT: RELATIONSHIP:

PHONE:

INSURANCE

☐ MEDICARE PRIMARY

MEDICARE #:

PRIMARY INSURANCE:

ID #:

GROUP #:

FACE TO FACE (F2F)

ENCOUNTER DATE (MM/DD/YY)

Primary reason for Home Health Care (List Medical Conditions/Diagnosis):

My clinical finding support the need for skilled nursing and/or therapy services because:

I certify my clinical finding support this patient is homebound because:

REQUESTED SERVICES

SKILLED NURSING - ☐ RN Evaluate & Treat ☐ PT ☐ OT ☐ ST ☐ HHA ☐ MSW ☐ Pre-Palliative Evaluation

SUPPORT SERVICES (A Medicare Covered benefit providing a skilled service above has to be provided):

☐ Labs & Date to be drawn:

☐ PT/INR monitoring/date to be obtained:

☐ Specific Wound Care Orders:

Physician Signature: Date: