ChristianaCare HomeHealth	**HomeHealth Order Form** Referral Phone: 302-428-2714 Referral Fax: 302-325-7075 Email: HHCentralIntake@Christianacare.org

PATIENT INFORMATION

Patient's Full Name_____

Date of Birth_____ ***(Please provide all demographic information.)***

Primary Reason(s) for HomeHealth Referral:_____

_____

_____

Healthcare Provider who will oversee HomeHealth:_____

_____

ORDERS

Discipline	Focus of Care
Occupational Therapy	
Physical Therapy	
Skilled Nursing	
Speech Therapy	

DIAGNOSIS / DIAGNOSES ***(Cannot use a symptom as a diagnosis)***

_____

_____

_____

ADDITIONAL INFORMATION / NOTES NEEDED ***(Please provide the following documents.)***

	History and Physical
	Order for HomeHealth Care
	Current Medication List
	Most Recent Office Visit Note, including documentation to support the reason for HomeHealth
	Face to Face visit - can be part of office visit note
	Special Orders – for example: wound care

PLEASE COMPLETE FOR PATIENTS WITH MEDICARE

Homebound Statement: Patient is homebound due to (limitations/ restrictions):_____

_____

I certify this Patient is under my care, and that I, or a Provider working with me, had a Face-to-Face encounter with this patient that meets the Provider Face-to-Face encounter requirements.

Provider Signature & Title_____

Date of Face-to-Face Encounter:_____

Signature of Person Completing Form:_____ **Date:**_____