GRANDCARE
HEALTH SERVICES

Referral for Home Health Care Services

Referral From: ☐ **Physician's Office** ☐ **Facility**

Name of Facility/Office: _____

Referral Contact Name: _____ **Contact Title:** _____

Contact Phone: _____ **Contact Fax:** _____

Patient Name: _____

Birth Date: _____/_____/_____ **Sex:** ☐ **M** ☐ **F** **Allergies:** _____

Please select the service(s) needed:

☐ **Skilled Nursing** ☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Other Disciplines:** _____

Specific Instructions:

_____

_____

_____

_____

Primary Diagnosis for home health services & comorbidities *(Please include all patient present & past diagnosis unless listed within #3 below):*

_____

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Physician Name	**Physician Signature**	**Date**

Please include the following information with the patient referral to ensure compliance with the Medicare Guidelines if the patient's primary or secondary insurance is Medicare:
1) Face to face encounter within 60 days (Needs to include skilled need for HH & homebound reason)
2) Face Sheet (Patient's Address, Contact Info & Insurance Info)
3) History & Physical and/or Recent Comprehensive Progress Note (Needs to include all patient diagnosis)
4) Name of primary physician (MD that will be following patient for home health services)

Please fax this page along with the above documentation to: (866) 975-7331.