DivineTouch Home Health Care, LLC

"Where Your Health and Well-being Matters the Most"

95 Vernon Street, Suite 301 Worcester, MA 01610

Phone: 508-304-6950 Fax: 508-304-6943

REFERRAL ORDER

Patient Information

Last Name: ______________________ First: ______________________ MI: ________

Address:______________________ City______________________ Zip: ________

DOB: ____________ Age: ________ ☐ Male ☐Female Ethnicity: ______________________

Social Security No.: ______________________ Home Phone: ______________________

Emergency Contact Name:______________________ Contact Phone:______________________

Relationship: ______________________ Alternate Phone: ______________________

Emergency Contact Address: ______________________

Physician Information

Referring Physician: ______________ NPI: __________ Phone: __________ Fax: __________

Referring Physician's Address: ______________________

Attending Physician: ______________ NPI: __________ Phone: __________ Fax: __________

Attending Physician's Address: ______________________

Primary Diagnosis:1. ______________________ ICD10 Code: __________

Secondary Diagnosis:2. ______________________ ICD10 Code: __________

Face to Face Encounter Date

Was the patient in an inpatient facility within the last 14 days? No ☐ Yes ☐

Certification of Homebound Status

My clinical findings from this encounter support the patient is homebound due to:

☐ Leaving home requires a considerable and taxing effort due to: ______________________

☐ Absences from home are infrequent of short duration or to receive healthcare treatment.

☐ Medically restricted due to immunosuppression, infections illness, risk of infection or injury, or __________

☐ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment.

Reason for Referral

Check Services Required

☐ Medication Management______________________

☐ Disease Management Education: ______________________

☐ Wound Care/Negative Pressure Wound Therapy: ______________________

☐ Other:______________________

Disciplines Ordered: ☐SN ☐PT ☐OT ☐ST ☐HHA ☐ MSW

Pay Source

Primary Insurance: ______________________ ID: ______________ GRP: __________

Policy Holder:______________________

FAX COMPLETED FORM TO (508) 304-6943 WITH THE FOLLOWING:

☐ Demographic Sheet ☐ Copy of insurance Card ☐ Most Recent Visit Notes ☐ Current List of Medication ☐ Vaccination Record ☐ Most Recent Lab Results

Physician Signature: ______________________ **Date:** __________

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