Physician Practices - Referral Form Guidelines

1. Document the date that the provider had the Face-to-Face visit with the patient and send a copy of it with the referral.

2. List the medical conditions/diagnoses that are the primary reason for home health care:
   - CHF, COPD, CVA, CABG, Diabetes, Wound Care, Cancer, Dysphagia, Knee/Hip Replacement

3. List the skilled services you are ordering based on the patient’s needs:
   - RN, PT, SLP
   - OT, MSW, RD or HHA may be ordered in addition to the above disciplines.

4. Describe the specific care ordered for each discipline:
   - CP assessment and teaching; Pain assessment and intervention; Medication management; Wound assessment and management; Treatment of gait abnormality; Improving functional status and mobility; Instructing use of assistive device

5. Describe the assistance required to leave home (include both when they apply):
   - List the assistive device used by the patient: cane, walker, wheelchair, special transportation such as ambulance or wheelchair van
   - Assistance of another person to leave home and why

6. Explain why there is a normal inability to leave home and why it is a taxing effort to leave home:
   - Be specific
   - Avoid using general terms

   Homebound Documentation

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair fast due to exacerbation of MS. Requires assistance of another to use wheel chair.</td>
<td>Requires wheelchair for mobility.</td>
</tr>
<tr>
<td>Short of breath with ambulation of 15 feet or less, requiring assistance of another person to ambulate safely.</td>
<td>Functional decline or weakness</td>
</tr>
<tr>
<td>S/P CABG 3 days. Medically contraindicated to leave home due to open wounds/potential for infection.</td>
<td>Unable to leave home due to recent CABG</td>
</tr>
<tr>
<td>Becomes severely disoriented when leaving home, even when accompanied by a caregiver.</td>
<td>Confusion or dementia</td>
</tr>
</tbody>
</table>

- **Physician signature and date required** (** only the physician can sign the form; no stamped signatures or dates**)
- **Physician printed name**