FAX

VOLUNTEER
HOME CARE

HOME HEALTH
FAX REFERRAL CHECKLIST

FAX: 731.664-7394

From:____________________

Pages:__________________

Date:___________________

- **Demographic Info/Cover sheet**
  include alternate phone #
- **Last office note**
  include statement from MD/provider that patient requires home health for diagnosis of ________ and the specific disciplines ordered (Nursing, PT, OT, ST, MSW and/or Aides)
  NOTE: office visit must be within the last 90 days, and must be signed and dated by the physician.
- **Doctors order for Home Health**
  this may be a computer generated order such as a consult request, or a prescription, but must be signed by the physician (e-signature is acceptable).
- **Insurance information**
- **Updated medications listing**
- **Any other pertinent clinical information**