MedStar Health

Home Healthcare Referral

FAX COVER SHEET

FAX: 888-862-6082

Referral documentation checklist

Type of referral: □ Start of care □ Resumption of care □ Add-on order

Documents and information required:

- ☐ Demographic sheet to include:
  - Patient's first and last name
  - Address and phone number of where patient will receive homecare services
  - Email address
  - Patient's primary language
  - Patient-selected representative or power of attorney
  - Insurance information
  - Emergency contact information
  - Caregiver information
- ☐ For patients with primary or secondary Medicare or Medical Assistance, a completed Face-to-Face encounter document must be signed by an eligible provider: physician, PA or NP
- ☐ Provider's homecare order (if Face-to-Face document not required)
- ☐ Referring provider's name and phone number
- ☐ Name and phone number of the provider who will follow the patient during home care and sign homecare orders as needed (if different than the referring provider).
- ☐ Medication profile
- ☐ Hospital transfer/discharge summary (if applicable)
- ☐ History and physical

Home infusion document and information requirements:

- ☐ Current labs
- ☐ Signed provider's order with medication, dose, frequency and duration
- ☐ PICC line X-ray, tip placement, length of PICC line
- ☐ Lab/blood work orders (if applicable) and the provider who should receive the results

NEXT STEPS AFTER REFERRAL SUBMISSION

Fax submission does not guarantee acceptance of the referral or an admission to homecare services.

- If the referral **cannot be accepted** or information/documentation is missing, you will receive a response via fax.
- **Accepted referrals** will be assigned to a homecare consultant who will contact you regarding the patient's anticipated admission.

Home Health Orders

Initial certification and orders must be signed and dated by the ordering provider. (MD, PA, NP)

Patient name: _____ **Patient DOB:** _____

Face-to-face encounter occurred on this date: _____ (should be within 90 days of start of care)
Provider attests that the Face-to-Face visit is related to the primary reason the patient requires home health services: ☐ YES
Is this a new order for home health or an add-on to an existing order? ☐ NEW ☐ ADD ON

Face-to-face encounter

Assessment of medical condition during this clinical visit: (check all that apply)

☐ Muscle weakness
☐ Shortness of breath
☐ Generalized weakness and fatigue
☐ Wound infection or non-healing wound
☐ Unsteady gait
☐ Immune-compromised
☐ Non-weight or partial weight bearing
☐ Pain
☐ Other: _____

Patient requires assistance to leave the home because: (check all that apply)

☐ High fall risk
☐ Muscle weakness
☐ Surgical procedure
☐ Wheelchair bound requiring assistance
☐ Open/draining wound
☐ Special transportation needs
☐ Aide of another person to safely leave home
☐ Requires use of assistive device (walker or cane)
☐ Cognitive deficits impair judgement safe navigation and decision making
☐ High fall risk from shortness of breath/distress after ambulating >10 feet
☐ Medical contraindication
☐ Other: _____

Home health care plan oversight

REQUIRED: Name the provider who is expected to oversee the home health plan of care and sign home health orders.

Provider name: Phone:

HOME HEALTHCARE ORDERS

Isolation precautions: ☐ Airborne ☐ Enteric ☐ Contact ☐ COVID-19 ☐ Droplet ☐ Enhanced Precautions

Advance Directives: ☐ YES ☐ NO
Do Not Resuscitate: ☐ YES ☐ NO
MOLST: ☐ YES ☐ NO

☐ **Skilled nursing**

☐ Medication management
☐ Disease management
☐ Nutritional management
☐ Anticoagulation
☐ LVAD
☐ Urinary Catheter
☐ Drain care
☐ Cardiovascular cardiopulmonary (CV/CP) assessment
☐ New cardiovascular medications
☐ Diabetes mellitus assessment/teaching
☐ Other:

☐ **Wound care**

Wound 1

Location:	Cleanse:
Apply:	Frequency:
Cover with:	Next treatment due:

Wound care comments: _____

Wound 2

Location:	Cleanse:
Apply:	Frequency:
Cover with:	Next treatment due:

Wound care comments: _____

Wound 3

Location:	Cleanse:
Apply:	Frequency:
Cover with:	Next treatment due:

Wound care comments: _____

Wound 4

Location:	Cleanse:
Apply:	Frequency:
Cover with:	Next treatment due:

Wound care comments: _____

☐ **Home health aide** (Not a personal care service; must also have skilled nursing ordered)

☐ **Infusion therapy**

IV medications

Start date:	End date:	Next treatment due:
Name and dosage:		
Frequency and duration:		
Type of line:	Location:	Date of insertion:
Line flush instruction:		

TPN

Start date:	End date:	Next treatment due:
Formula and dosage:		
Type of line		
Location:	Date of insertion:	
Line flush instruction:		

Tube feeding

Start date:	End date:	Next treatment due:
Formula and dosage:		
Route:	Admin method:	
Flush instruction:		

Infusion therapy comments: _____

☐ **Labs** ☐ Venipuncture ☐ Central Line
☐PT/INR ☐CBC ☐BMP ☐LFT ☐CMP ☐CRP and ESR ☐CK ☐Vanc level (random) ☐Vanc level (trough)

☐Other: _____

Start date:	Frequency:	
Goal INR range:		
Physician following labs:	Phone:	Fax:

Therapy orders

☐ **PT evaluation and treatment**
Check below, if applicable
- ○ PT evaluation and treatment
- ○ PT to assess for OT (check only if OT not ordered)
- ○ PT to assess for SN (check only if SN not ordered)
- ○ Gait training
- ○ Transfer training
- ○ Bed mobility
- ○ Therapeutic exercise and home exercise
- ○ Balance and neuro reed training
- ○ Home safety assessment and training
- ○ Pain management/education
- ○ Fall prevention
- ○ Staple removal surgical wound care
- ○ Wheelchair training
- ○ Prosthetic training
- ○ Adaptive equipment/DME training
- ○ Skin integrity education
- ○ Edema management
- ○ Other: _____

☐ **OT evaluation and treatment**
Check below, if applicable
- ○ OT evaluation and treatment
- ○ Transfer training
- ○ ADL training
- ○ IADL training
- ○ Low vision
- ○ Cognitive training
- ○ Bed mobility
- ○ Balance training
- ○ Adaptive equipment training
- ○ Energy conservation
- ○ Therapeutic exercise and home exercise
- ○ Home safety training
- ○ Pain management
- ○ Fine motor training
- ○ Sensory integration training
- ○ Orthotics and splinting
- ○ Other: _____

☐ **SLP evaluation and treatment**
Check below, if applicable
- ○ ST evaluation and treat
- ○ Dysphagia training
- ○ Aphasia training
- ○ Cognitive training
- ○ Voice and communication training
- ○ Auditory training
- ○ Comprehension training
- ○ Other: _____

Weight bearing restrictions:
- ☐ NWB RLE (non-weight bearing right lower extremity)
- ☐ NWB LLE (non-weight bearing left lower extremity)
- ☐ Heel WB, Transfers on RLE (heel weight bearing, transfers only right lower extremity)
- ☐ Heel WB, Transfers only LLE (heel weight bearing, transfers only left lower extremity)
- ☐ TTWB RLE (toe touch weight bearing right lower extremity)
- ☐ TTWB LLE (toe touch weight bearing left lower extremity)
- ☐ WBAT RLE (weight bearing as tolerated right lower extremity)
- ☐ WBAT LLE (weight bearing as tolerated left lower extremity)
- ☐ Other: _____

Precautions and protocols:
- ☐ Posterior/anterior hip precautions
- ☐ Spinal precautions
- ☐ ROM Protocol
- ☐ Other: _____

☐ **Medical social worker** (must also have skilled nursing or PT ordered)

Referring provider information (physician, PA, NP)

Provider signature: _____ Date: _____ Time: _____

Printed name: _____ NPI: _____

Pager/phone: _____

Provider practice/clinic name: _____ Phone number: _____