Qura Healthcare Inc

4993 Golden Foothill Pkwy Suite 2, El Dorado Hills, CA 95762

Tel: (916) 936-4231 Fax: (916) 936-4865

Referral Form /Face-to-Face Encounter Document

Patient Name: _____ **Phone:** _____

Address: _____

Patient DOB: _____ **SSN**: _____ **Medicare/Insurance #:** _____

Contact Person: _____ **Phone #:** _____

Diagnosis: _____

***Please provide progress notes and current medications.**

I attest that I had a Face-to-Face encounter with the above patient on: _____ (month/day/year)

My clinical findings support the need for home health services as follows:

_____

_____

_____

MD's clinical findings to support the need for below services:

This must be in relation to the medical condition you saw the patient for on the above encounter. Write the reason that you feel the patient needs home care services, for example, needs assessment and monitoring of the condition, teaching/education related to the condition.

I certify my clinical findings/diagnosis support that this patient is *homebound* per CMS guidelines due to:

_____

_____

Homebound Reasons (Medicare requirement for home care: Patient must be homebound)

(Examples: leaving home is a taxing effort, Patient is unable to leave home unassisted or due to medical restriction, SOB with exertion, unsteadygait, cognitive impairments, poor vision, subject to infection if leaves home)

CHECK CLINICAL SERVICES REQUIRED

SKILLED NURSING

- ☐ Evaluation and skilled interventions
- ☐ Wound care / decubitus care
- ☐ Monitor response to new or changed medication
- ☐ Foley catheter / NG-tube insertion and management
- ☐ Patient / caregiver instruction (EG, meds, skins / wound care, IV's and disease processes)
- ☐ Diet counseling
- ☐ Renal Failure
- ☐ Diabetes Management
- ☐ Other (explain)

_____

_____

PHYSICAL THERAPY EVALUATION

- ☐ Home safety/Family teaching/Equipment
- ☐ Mobility
- ☐ Strength / ROM/ Gait
- ☐ Fall Prevention
- ☐ Pain Management
- ☐ Other (Explain) _____

OCCUPATIONAL THERAPY EVALUATION

- ☐ Self-Care / ADL
- ☐ Home Safety / family Training / equipment
- ☐ Energy Conservation
- ☐ Mobility / transfer skills
- ☐ Other (Explain) _____

SPEECH THERAPY EVALUATION

- ☐ Speech language deficits
- ☐ Cognitive deficits
- ☐ Swallowing evaluation
- ☐ Other (Explain) _____

MEDICAL SOCIAL WORK

- ☐ Psychosocial evaluation related to patient illness and care
- ☐ Short-term therapy related to coping with illness and family support
- ☐ Community resource planning and placement
- ☐ Conflict resolution
- ☐ Other (Explain) _____

_____

☐ **HOME HEALTH AID**

Reason: _____

SPECIAL INSTRUCTIONS:

_____

_____

_____

Please provide progress notes and current medications.

Certifying Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Certifying Physician Signature: _____ Date: _____

Please Sign and Fax Back to 916-936-4865