MedStar Health

FAX COVER SHEET

Home healthcare referral

FAX to: 888-862-6082

Referral documentation checklist

Type of Referral: ☐ Start of care ☐ Resumption of care

Documents/information needed:

- ☐ Demographic sheet to include:
  - o Patient's first and last name
  - o Address and phone number of where patient will receive homecare services
  - o Email address
  - o Patient's primary language
  - o Patient-selected representative or power of attorney
  - o Insurance information
  - o Emergency contact information
- ☐ For patients with **primary or secondary Medicare or Medical Assistance**, a completed Face-to-Face encounter document must be signed by a **physician** (PA or NP signature not acceptable)
- ☐ Physician's homecare order (if Face-to-Face document not required)
- ☐ Referring physician's name and phone number
- ☐ Name and phone number of the physician who will be following the patient for home care services
- ☐ Medication profile
- ☐ Hospital transfer/discharge summary (if applicable)
- ☐ History and physical

Additional items needed for infusion referrals:

- ☐ Current labs
- ☐ Signed physician'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 physician who should receive the results

Questions? Call our Patient Intake Center at **800-862-2166.** Choose option 2.

FURTHER ACTION REQUIRED! Fax submission does not guarantee start-of-care. Please call to verify receipt and confirm start-of-care date.

MedStar Health Home Care Face-to-Face Progress Note and 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: _____/_____/_____ (should be within 90 days of start of care)

Is this visit related to the primary reason the patient requires home health services? ☐Yes ☐No

Clinical Findings

Patient's medical condition or diagnosis of _____results in:
(Check all that apply)

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

Homebound Status

Due to the above stated illness, injury or surgical procedure (medical condition or diagnosis) and associated clinical findings, the patient is homebound because of his/her inability to leave home except with aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated.

MUST COMPLETE BOTH SECTIONS BELOW TO MEET HOMEBOUND ELIGIBILITY CRITERIA.

***Patient requires the following assistance to leave the home**: (Check all that apply)

☐Cane ☐Walker ☐Wheelchair ☐Aid of another person ☐ Medically contraindicated

***Patient cannot leave the home or requires assistance to leave the home because**: (Check all that apply)

☐ High fall risk due to gait instability ☐ Muscle weakness ☐Wound infection or non-healing wound ☐ Patient is bedbound ☐ Cognitive deficits impact judgment, impair ability to safely navigate and prevent decision making for safety

☐ Shortness of breath/distress after ambulating more than 10 feet results in high risk for falling ☐ Recent LE/UE surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation.

☐ Other:_____

Advance Directives: ☐YES ☐NO

Do Not Resuscitate: ☐YES ☐NO

MOLST Form (patients living in Maryland): ☐YES ☐NO

Home Healthcare Orders

☐ **Skilled Nursing** (Check all that apply)

☐ Medication management ☐Disease Management ☐Nutritional Management ☐Drain Care

☐ Anticoagulation ☐ New cardiovascular medications ☐ Diabetes Mellitus Assessment/Teaching

☐ Cardiovascular Cardiopulmonary (CV/CP) Assessment

☐ Wound Care: (specify wound care, negative pressure wound care and treatment)_____
_____
_____
_____

☐ Other _____
_____
_____

Patient Name_____

☐ **Infusion Therapy** (Check all that apply)

- **IV medications** (antibiotics, chemotherapy, pain, cardiac)

Name and dosage:_____
Frequency and duration:_____
Type of line: _____Location: _____Date of insertion:_____
Line Flush Instructions:_____

- **TPN**

Formula and dosage:_____
Start Date: _____Type of Line:_____
Location: _____Date of Insertion:_____
Line Flush Instructions:_____

- **Cathflo® (Alteplase)** 2mg for each occluded lumen, per manufacturer instruction, as needed, while patient is on IV therapy.

- **Tube Feeding**

Enteral Formula and dosage:_____

Start Date: _____ Route: ☐ PEG ☐ PEJ Administration Method: ☐Pump ☐Gravity ☐Bolus
Flush Instructions:_____

☐**Labs** (Check all that apply)

Venipuncture: ☐ CBC ☐BMP ☐LFT ☐CMP ☐CRP & ESR ☐CK ☐Vanc Level (random) ☐Vanc Level (trough)

☐Other_____

☐ PT/INR:_____times/week. ☐ May use PT/INR meter.
• Planned date for first INR:_____ • Goal INR Range:_____

Send lab results to:_____ Phone: _____Fax:_____

☐**Therapy Orders** (Check all that apply)

☐ **Physical Therapy** ☐ PT assess for SN ☐ **PT assess for OT** ☐ **Occupational Therapy** ☐ **Speech Therapy**
(must have nursing or PT ordered)

□ Provide gait training, strengthening and/or balance exercises to restore the patient's ability to walk safely without pain.
□ Increase strength and endurance and restore ROM
s/p_____surgery.
□ Evaluate for assistive devices and/or environmental modifications needed to address ADL deficits to improve safety with transfers and ambulation.
□ Teach the patient caregiver compensatory strategies for cognitive deficits.
□ Teach patient caregiver compensatory environmental modifications for safety.
□ Evaluate and treat dysphagia.
□ Evaluate and treat aphagia.
□ Provide maintenance therapy to prevent or slow a decline in condition.
□ Other
(describe):_____

☐ **Medical Social Worker** (Must also have skilled nursing, physical therapy or speech therapy ordered)

☐ **Home Health Aide** (Not PCA service; must also have skilled nursing ordered)

Referring Provider Information (physician, PA, NP)

Provider Signature: _____**NPI #:**_____ **Date:**_____ **Time:**_____

Print Name: _____**Pager/Phone:**_____

Physician Practice or Clinic Name:_____ **Phone #:**_____