49 East Huntington Dr., Arcadia, CA 91006
Phone: (626) 821-0822 / Fax: (626) 821-6068

Formerly known as
BALANCED LIVING
A HOME HEALTH AGENCY, INC

Home Health Referral

Patient Name: ______________________________ Patient contact number: ________________________

Referring Physician: **Diagnosis:** ________________________________

F2F encounter date: **F2f done by:** __________________**or @hospital/snf**

This encounter with the patient was necessitated by the following medical condition (s) which is the primary reason for home health care: ____

____

My clinical findings support the need for Skilled services/interventions because: (describe services the clinician may perform in the home, i.e. assess, teach, wound care, gait training, HEP, Strengthening, fall prevention program, Home Safety program).

- ◯ **Skilled nursing care** for: ____
- ◯ **Skilled Physical therapy** for: ____
- ◯ **Skilled Occupational Therapy** for: ____
- ◯ **Skilled Speech Therapy** for: ____
- ◯ **Certified Home Health Aide** for: ____
- ◯ **Medical Social worker** for: ____
- ◯ **Respiratory Therapist** for: ____

Due to the clinical findings above the patient is homebound. Below marks are the results of the patient diagnosis causing homebound status

Please mark all that apply:

◯ Unable to leave home unassisted ◯ Requires assisted device (s) ____________ ◯ Severe dizziness
◯ Temporarily homebound due to surgery or illness ◯ Patient at fall risk ◯ Unable to ambulate
◯ Intractable pain and/or pain that affects patient's mobility ◯ Sever dyspnea on exertion
◯ Residual weakness due to surgery or illness ◯ Medication that limits patients physical abilities
◯ Exceedingly difficult for patient to leave even with assistance ◯ Compromised mental status
◯ Cognitive status makes Patient unable to leave home without supervision
◯ Inability to safely navigate stairs, uneven sidewalks and curbs
◯ Other: ____

Surgical date (if applicable): ______________ **Hospital Discharge Date** (if applicable): _____________

I certify that this patient is under my care and that I, or a nurse practitioner, physician's assistant, or a physician working with me from my office or a physician who cared for the patient in an acute or post acute facility had a face to face encounter related to the primary reason the patient requires home health that meets CMS requirements. This order is a part of my patients medical record from our F2F visit.

Physician signature ________________________________ Date

Please fax this along with supporting documents for home health, and patient demographic to **626.821.6068** (supporting documents - patient physician note that documents the need for home health)