enhabit
Home Health & Hospice

Home health referral form

Referral source: _____ Contact: _____ Phone: _____

Area manager: _____ *Required field

PATIENT INFORMATION

*Patient full name: _____ *Phone: _____

*DOB: _____ *Medicare #/MBI: _____ SSN: _____

*Address (of care provision): _____

*Emergency contact: _____ *Phone: _____

*Primary reason(s) for referral: _____

*Health care practitioner who will oversee home health services: _____

ORDERS

Discipline	Focus of care
○ Skilled nursing	
○ Physical therapy	
○ Occupational therapy	
○ Speech therapy	
○ Other	

Additional orders or information about the patient you would like us to know so we can provide excellent care:

*Health care practitioner signature and credentials: _____

*Health care practitioner printed name: _____ *Date: _____

Requested information - *Please send these documents to support a safe patient hand-off*

- Recent clinical notes, H&P, labs
- F2F encounter visit note
- Most recent HbA1C (diabetic patients)
- Current medication list
- Most recent assessment of primary reason for home health