

**E-Z FAX** Patient Referral Form

**FAX To:** (559) 226-2038

Please confirm receipt of your fax  
by making a quick call to our  
Customer Entry Department @ 248-0131 x102

**Requested Start of Care date** (on or before):  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**From:**

Doctor/facility:

Contact name:

Date: \_\_\_\_\_ Total # of pages: \_\_\_\_\_

FAX #: \_\_\_\_\_ Tel #: \_\_\_\_\_



Please attach the following **essential** information:

**\*Face Sheet      \* Demographics      \*Copy of Insurance Card      \* History & Physical**

Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_



**Date of Face to Face encounter:** Certification that this patient is under your care and that you, your nurse practitioner or physician's assistant working with you, had a face-to-face encounter that meets the physician face-to-face requirements per CMS regulations (Month/Day/Year): \_\_\_\_\_

**Reason for encounter** The encounter with the patient was in part/whole for the following medical condition/s, which is the primary reason for home health care: \_\_\_\_\_

**I certify that , based on my findings, the following services are medically necessary home health services**

**(check all that apply):**  Skilled Nursing     Physical Therapy     Occupational Therapy  
 Speech Therapy     Medical Social Worker     Home Health Aide

**My clinical findings support the need for the above services because:**

**I also certify that my clinical findings support that this patient is homebound because (i.e. absences from the home require considerable and taxing effort and are for medical reasons, religious services or infrequently/of short duration when for other reasons):**

 Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

