Brema Healthcare, Inc.
2727 LBJ FWY, Suite 324, Dallas , Texas 75234
PH: 214-339-9466 | FAX: 214-339-2733 |
www.bremahhc.com

PATIENT REFERRAL FORM

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: TX Zip: _____Phone: _____ Phone2: _____

Emergency Contact: _____ Emergency Contact Number: _____

DOB: _____ SSN: _____Insurance ☐ Medicare ☐ Medicaid ☐ Private Insurance

Primary: _____ ID#: _____ Secondary: _____ ID#: _____

Referral Agency: _____ Case Manager: _____ Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Last Physician Appointment/Encounter Date: _____ Date of Planned Initiation of Services: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Diabetic Yes/ No: _____Allergies: _____Most recent medications list includes Yes/ No

Home Health in Past or Current? _____ Date: _____

Name of Past or Current Home Health Agency: _____ Phone: _____

Comments: _____

ORDERS	**THERAPY ORDERS**
Skilled Nurse to Evaluate for Home Health Need	☐ Physical Therapy Evaluation & Treatment
☐ Medication Management ☐ Blood Draws	☐ Fall Prevention Program
☐ Teaching for Disease Process/Nutrition	☐ Occupational Therapy Evaluation & Treatment
☐ DM Management ☐ IV Wound Care	☐ Speech Therapy Evaluation & Treatment
☐ Medical Social Worker at Home	☐ Home Health Aid (Bathing, Light Housekeeping)

MD/PHYSICIAN SIGNATURE: _____ **Date:** _____

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FACE TO FACE ENCOUNTER DOCUMENTATION

(*All fields required for Medicare Patient)

Patient Name: _____ DOB: _____

In accordance with the 2015 Home Health PPS Final Rule. "It is permissible for HHA to communicate with and provide information to the certify physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient." I certify that this patient is under my care and that I, or a nurse practitioner or physician assistant working in collaboration with me or under4 my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with the patient on: ____/____/_____Date

1. **Certification and Date of Face-to-Face Encounter**
   I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist or physician's assistant working with me, had a face-to-face encounter with this patient on:

   Date of In-Person Visit: _____ (mm/dd/yy)

2. **Medical Condition Related to Home Health Services**
   The encounter with the patient was in whole, or in part, for the following medical condition, which is the, for Primary Diagnosis & Reason for the Encounter home health care: _____
   _____

3. **Certification of Medical Necessity**
   I certify that based on my clinical findings the following home health services are medically *necessary to provide the care and treatment as identified (check all that apply):*

☐ Nursing Services ☐ Therapy Services ☐ C.N.A Services ☐ MSW

Additional Clinical Findings to Support the need for Home Health Services: _____
_____

4. **Certification of Homebound Status**

Further, I certify that the patient is homebound – requiring considerable and taxing effort to leave home - My clinical findings from this encounter support the patient is homebound due to the above condition(s) because:

☐ Leaving home requires a considerable and taxing effort

☐ Absences from home are infrequent, of short duration or to receive healthcare treatment

☐ Medically restricted due to immunosuppression, infectious illness, risk of infection or injury, or_____
_____

Other: _____

PHYSICIAN INFORMATION & SIGNATURE

Referring Physician Name: _____ NPI#: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ Phone 2: _____

MD/PHYSICIAN SIGNATURE: _____ DATE: _____