

Referral Form for Nightingale Care

Referring Source: _____

Referral Date: _____ Discharge Date: _____ Physician Ordered Start of Care Date: _____

Addres: _____ NPI: _____

Type: Physician/NP SNF Hospital

Patient Name: _____ DOB: _____

Dx (ICD10): _____ Insurance: _____ Member ID: _____

Patient is Home Bound: ☐ Yes ☐ No Teachable Caregiver: ☐ Yes ☐ No ☐ Unknown

Home Care Disciplines Ordered:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Aide

I certify that the above patient is under my care and requires the above listed home health services. The professional services noted above are appropriate for the individual's diagnosis, prognosis, functional limitations, and medical condition.

Face to Face:

By my signature below, I certify that I, or a collaborating advance practice nurse or a physician assistant under my supervision, or another qualifying provider, conducted and documented a face-to-face encounter with the individual within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification of medical necessity.

Date last seen: _____

Doctor Signature ☒ _____ Date _____

Doctor Printed Name: _____

Physician to follow patient and sign Plan of Care/485:

Name: _____ Ph: _____ Fax: _____

Please include the following with this home care order:

- 1) Patient H & P
- 2) Signed Patient Encounter Note(s)
- 3) Progress Note(s)
- 4) Any other relevant/recent patient records
- 5) Face Sheet for insurance information
- 6) Other