VNSNY Referral Form

Email Referral to: **VNSNY_New_Referral@vnsny.org**

Phone Referral and Inquiries: **1-866-632-2557** Fax Referral: **212-290-3939**

PATIENT AND INSURANCE INFORMATION

PATIENT INFORMATION

Last Name _____

First Name _____

Date of Birth _____/ _____ / _____ ◉Male ○Female

Patient Address _____

_____ Apt # _____

City _____ State_____ Zip _____

Primary Phone _____

Other Phone _____

Language Spoken _____

Emergency Contact/Relationship _____

Contact Primary Phone _____

Was the patient discharged from a facility in the past 14 days? ○Yes ◉No

If so, facility name _____

DATE OF DISCHARGE_____/ _____ / _____

Was this stay Inpatient? ◉Yes ○No? ED Visit ◉Yes ○No?

Observation Stay ○Yes ○No?

REFERRAL SOURCE Name _____

Address _____

Phone _____

PATIENT INSURANCE INFORMATION

Medicare No. _____

Medicaid No. _____

Insurance Carrier (Name and Authorization No.)

_____

Subscriber Name _____

Policy No. _____ Group No. _____

Secondary Insurance Information

Insurance Carrier (Name and Authorization No.)

_____

Subscriber Name _____

Policy No. _____ Group No. _____

REQUESTED START OF CARE DATE: _____/ _____/ _____

FACE-TO-FACE CERTIFICATION

☐ FOR HOME HEALTH SERVICE UNDER MEDICARE:

I am a Medicare PECOS enrolled physician and I certify that:

This patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, and additionally may need occupational therapy. The patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

☐ FOR HOME HEALTH SERVICE UNDER MEDICAID:

I am a Medicaid OPRA enrolled physician and I certify that:

This patient needs nursing care, physical therapy and/or speech therapy and additionally may need occupational therapy that is medically necessary. This patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

_____/_____/_____ **ENCOUNTER DATE**

HOME CARE DIAGNOSIS

DIAGNOSES (Please attach Medical History and Progress Notes.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

HOME CARE ORDERS

SKILLED NURSING SERVICES

☐ Observation/Assessment/Education (Specify plan) _____

_____

☐ Medication Management _____

☐ Disease Management _____

☐ Wound Care _____

☐ Injections _____

☐ IV Therapy (Medicare) _____

☐ Behavioral Health (Medicare) _____

☐ Other Skilled Nursing Service _____

THERAPY SERVICES

☐ Physical Therapy _____

_____

☐ Occupational Therapy _____

_____

☐ Speech Language Pathology _____

_____

ADDITIONAL SERVICES

☐ Other _____

_____

PHYSICIAN

Print Physician Name _____ Physician Signature _____ Date ___/___/___

Physician Address _____ Phone _____ Fax _____

Office Contact Name _____ Phone _____ Email _____

What is the definition of being "homebound?"

"Homebound" means a patient is unable to leave home without considerable and taxing effort.

CRITERIA 1	AND	CRITERIA 2
Needing the aid of a **supportive device** due to illness or injury: ■ Crutches, canes ■ Wheelchair ■ Walker ■ Use of special transportation ■ Assistance of another person in order to leave home, including for cognitive or psychiatric impairments **OR** Having a condition where leaving home is **medically contraindicated.**		Normal inability to leave home and leaving home requires considerable and taxing effort: ■ Exacerbated symptoms from leaving home, e.g., shortness of breath, pain, anxiety, confusion, fatigue

Patients who leave home infrequently for short durations or for health care **MAY STILL** be considered homebound. These situations may include (but are not limited to):

- Attending a religious service
- Going to get a haircut
- Walking around the block
- Attending a family event, funeral, graduation or other unique event
- Receiving outpatient kidney dialysis
- Receiving outpatient chemotherapy or radiation therapy

Physician documentation in the patient record must support how/why the patient is homebound and requires skilled services.

EXAMPLE 1	EXAMPLE 2
Patient is confined to the home due to unsteady gait and needs assistance to ambulate secondary to CVA. The patient needs home nursing care for medication teaching and disease management and physical therapy for falls risk reduction and a home exercise program.	Patient is confined to the home due to s/p recent total knee replacement and currently walker dependent with painful ambulation. PT is needed for therapeutic exercise and gait training.

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