A Plus Home Health, Inc. Referral Date: _____

Physician Referral Form

Patient Information

Full Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female ☐ Other: _____ Phone Number: _____

Residence Address: _____

(Number/Street) (City) (State) (Zip)

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Family Contact: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

Referral Source Information

Name of Referring Provider/Agency: _____

Provider/Agency Phone Number: _____ Fax: _____

Provider/Agency Email: _____

Relationship to Patient: _____ Next Appointment Date: _____

Please provide a copy of:

1. Last Visit Note
2. Medication Profile
3. History and Physical

Reasons for Referral (select all that apply)

☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Skilled Nursing
☐ Home Health Aide
☐ Licensed Clinical Social Worker (LCSW) Services
☐ Evaluation Only
☐ Evaluation and Treatment
☐ Care Coordination
☐ Other: _____

Diagnosis/Medical Condition

Diagnosis:

1. _____
2. _____
3. _____
4. _____

Any Known Allergy(s): _____

Additional Information: _____

Physician Information (Required for Approval)

Physician's Name: _____ Phone Number: _____

Physician's Address: _____

(Number/Street) (City) (State) (Zip)

Consent and Acknowledgement

By signing below, I acknowledge that I have reviewed the information provided and authorize A Plus Home Health, Inc. (Agency) to contract the patient and initiate services.

Referring Provider Signature: _____ Date: _____