HOME HEALTH REFERRAL FORM

Thank you for your referral! Please fax this referral sheet with the following:

1) H&P / Discharge Summary 2) Current Medication List 3) *Medicare patients only*: completed Medicare Certification ("Face to Face")

Agency referred to:	**Phone**	**Fax**	**E-mail**
SILVERLINE HOME HEALTH	**805.288.1353**	**424.426.3433**	**Intake@silverlinecares.com**
Referral Source:	**Phone:**	**Fax:**	**E-Mail**

Patient Demographics

First Name		**Last Name**		**M.I.**	
Date of Birth		**Sex** ☐ M ☐ F	**Home Phone**	**Mobile Phone**	
Home Address	**Street**		**City**		**Zip**
Service Location (if not home address)	**Street**		**City**		**Zip**
Caregiver / Emergency Contact			**Phone**		
Insurance		☐ **Medicare** ☐ **Medi-Cal** ☐ **Commercial Insurance**:			**ID #**
Diagnosis(es)					

Please Check All Home Health Services Ordered

- ☐ Skilled Nursing, Evaluate & Instruct
- ☐ Home Infusion (Please attach orders separately)
- ☐ Physical Therapy, Evaluate & Instruct
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Medical Social Work

Comments:

Referring Physician:	Phone: Fax:
Following Physician (if different):	Phone: Fax:

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy, occupational therapy, and/or speech therapy. The patient is under my care, and I have authorized the home health services

Physician Signature: Date:

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