# VNSNY Physician Referral Form

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 _____

City _____ State_____ Zip _____

Phone #1 _____

Phone #2 _____

Language Spoken _____

Emergency Contact/Relationship _____

_____

Day Phone _____

Evening Phone _____

**DATE OF DISCHARGE FROM FACILITY (IF APPROPRIATE):** _____/_____/_____

### 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:** _____/_____/_____

## HOME CARE DIAGNOSIS

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

## HOME CARE ORDERS

### SKILLED NURSING SERVICES

☐ Observation/Assessment _____

_____

☐ 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

☐ Assess for Home Health Aide _____

_____

_____

☐ Other _____

_____

## 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 _____/_____/_____.

## PHYSICIAN

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

Physician Address _____ Phone _____ Fax _____

Office Contact Name _____ Phone _____

# 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:<br>■ Crutches, canes<br>■ Wheelchair<br>■ Walker<br>■ Use of special transportation<br>■ Assistance of another person in order to leave home, including for cognitive or psychiatric impairments<br>**OR**<br>Having a condition where leaving home is **medically contraindicated.** | | Normal inability to leave home and leaving home requires considerable and taxing effort:<br>■ 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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