IDEAL CHOICE HOME HEALTH

14852 Ventura Blvd., Suite 207
Sherman Oaks, CA 91403
P: (747) 877-8440 • **F:** (747) 877-8441
Email: referrals@idealchoicehomehealth.com
idealchoicehomehealth.com • Mon–Fri 10 a.m.–5 p.m.

HOME HEALTH REFERRAL

Required: Patient identification, home address (and service address if different), insurance information, diagnosis, requested services, and physician information/signature.

Please include: Recent clinical notes or discharge summary, current medication list, and applicable face-to-face encounter documentation. Additional orders or documentation may be requested.

Submit the completed form and supporting documents by fax or approved secure email.

Patient Demographics

First Name Required			**Last Name**			**M.I.**	
Date of Birth Required		**Sex** M F	**Home Phone**		**Mobile Phone**		
(Provide at least one patient or alternate contact phone number.)							
Home Address Required	**Street**			**City**		**Zip**	
Service Address (required only if different from home address)	**Street**			**City**		**Zip**	
Caregiver / Emergency Contact Optional				**Phone**			

Insurance Required

Original Medicare **Medicare Advantage / Other Insurance** **VA Community Care**

Plan / Payer Name: _____ **Member ID:** _____

Diagnosis(es) Required

Face-to-Face Encounter Date: _____

Requested start date (Optional) _____

Hospital discharge date (If applicable) _____

Home Health Orders

Please check all home health services ordered (Requested services — Required)

Skilled Nursing, Evaluate & Instruct

- Cardiac
- Diabetes
- Medication
- Pain
- Respiratory
- Post-op care
- Injections
- Labs / venipuncture

Specialized nursing needs:

- Wound care / NPWT (nursing care)
  - Type: _____
  - Location(s): _____
  - Stage (if applicable): _____
- IV infusion therapy
  - Antibiotics
  - Hydration
  - IVIG

IVIG: Please inquire about your area.

- PICC / midline / central line care
- Catheter / ostomy / drain care

Other / additional nursing orders: _____

Physical Therapy, Evaluate & Instruct

- Ambulation / Gait / Wheelchair
- Balance
- Range of Motion
- Transfers / Bed Mobility
- Safety / Falls
- Weakness / Strengthening

Other: _____

Speech Therapy, Evaluate & Instruct

- Cognition
- Hearing
- Language / Voice
- Swallowing

Other: _____

Medical Social Work, Evaluate & Instruct

Part of an eligible skilled home health plan.

- Psychosocial support related to illness/recovery
- Community-resource guidance related to care plan

Occupational Therapy, Evaluate & Instruct

- ADLs
- Energy Conservation
- Sensory Dysfunction
- Orthotics / Adaptive Equipment

Other: _____

Home Health Aide — Personal Care Assistance

Bathing, grooming, dressing and related hygiene support as ordered under the home health plan of care.

Additional orders / comments: (Optional)

Detailed treatment orders may be attached when necessary.

Physician Information

Referring Physician (please print) Required		**NPI**	**Phone** / **Fax**
Following Physician (if different)	same as referring physician above		**Phone** / **Fax**
Physician Signature Required	*By signing, I order the home health services selected above, subject to clinical assessment and applicable eligibility requirements.*		**Date** Required

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Questions? Call intake at (747) 877-8440 | idealchoicehomehealth.com