PRECISION CARE SERVICES
REFERRAL FORM

Monday-Friday 8am - 5pm
Fax to (912)-556-4095
Please call (912)-556-4050 to confirm receipt.

After hours, weekends, and holidays: Please call (912)-556-4050 leave your name and phone number. The triage nurse will return your call.

Patient Demographics

PATIENT NAME: _____ DOB: ____/____/_____ SSN: _____-_____-_____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

D/C ADDRESS: _____ CITY: _____PHONE #: _____

CONTACT PERSON: _____PHONE #: _____ RELATIONSHIP: _____

Height: _____ Weight: _____ Date physician last saw the patient: _____

Is the physician willing to follow for home care: **YES** or **NO** Start of Care Date: _____

Diagnosis: _____

Allergies: _____

INSURANCE INFORMATION:

Primary ☐ Medicare Medicaid Anthem

☐ UHC BCBS Other Commercial Ins

Group#:_____ WC#_____

Subscriber:_____ Phone:_____

Relationship: Self Spouse Parent Grandparent

☐ Sibling Friend Child Other:_____

Precision Health Care Advanced Illness Management Program

☐ Advanced Care Planning ☐ Goals of Care

☐ Symptom Management ☐ Other: _____

THERAPY SERVICES

☐ ADL Training

☐ Home Safety Assessment

☐ Mobility Training

☐ Precautions:

LABS: CBC with differential ☐ CPK

☐ BMP ☐ CRP ESR ☐ Lytes:_____

Trough after: 3rd / 4th / _____ dose / _____date

Other Labs: _____

Report Labs to:_____

NURSING SERVICES : Physical & Environmental Assessment

☐ Assess for needs CHF/COPD

☐ Education ☐ Lab:_____

☐ Diabetic Care ☐ Other:_____

☐ Wound Care:_____

SOCIAL WORK SERVICES:

☐ Medicaid Follow-up

☐ Community Resources ID & Referral

☐ Other:_____

IV Infusion Drug Name (1) _____

Dose:_____ Frequency:_____

Route:_____Start Date:_____

Stop Date:_____

1st Dose: No Yes, include Anaphylaxis Kit

CURRENT IV ACCESS: (Circle One)

☐ PICC Line Central Line (Single/Double/Triple Lumen)

Date Placed:_____ Port Needle Size:_____

Accessed:_____ Midline Length:_____

IV to be placed: Peripheral IV: will need to be placed

☐ SubQ ☐ IntraMuscular

Physician Signature: _____ Date signed: _____

Physician's office contact: _____ Number: _____-_____-_____

OFFICE USE ONLY

Date Received: _____/_____/_____ Time Taken: _____ Person Taking Referral: _____

PHYSICIAN CERTIFICATE OF MEDICAL NECESSITY

Face-to-Face Encounter

Patient Name: _____

Encounter Date and Reason for Encounter

I certify that I, or a qualified non-physician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below due to the medical condition also listed below, which relates to the primary reason the patient requires home health services.

Encounter Date: _____ Diagnosis/Reason: _____

Need for Home Health Services

I certify that based on my findings:

a. Home Health Services are medically necessary for this patient (check all that apply):

- ☐ Nursing
- ☐ Home Health Aide
- ☐ Medical Social Work
- ☐ Respitory Therapy

b. This patient is homebound based on the following information:

_____

_____

My clinical findings support the need for the above services because:

_____

_____

_____

_____

I certify that this patient is under my care, or has been referred to another physician having professional knowledge of the patient's condition. Services ordered above are needed to treat condition for which patient was hospitalized and/or seen in the office. The composed above information is based on my clinical judgment relating to this patient's medical condition.

Certifying Physician Signature: _____ Date of Signature: _____

Physician Printed Name: _____