Home Health Hawai'i Island
563 Kaumana Drive Suite# 200
Hilo, HI 96720
Ph: 808-900-7232 Fax: 808-800-2785

**FACSIMILE TRANSMITTAL**

| **TO:** Dr. | **Fax #:** |
|---|---|
| **FROM:** | **Fax #:** 808-800-2785 |
| **PAGES:** 3 page(s) including cover page | **Date:** |
| **RE:** Patient- | |

Aloha Provider,

Please review home health service request and kindly respond. If anyone has questions please call our office at 808-900-7232.

Mahalo,
Matthew "Zack" Canada RN/Patient Care Coordinator
ph: 808-900-7232 Fax: 808-800-2785 | c: 808-852-0560
a: 563 Kaumana Drive Suite# 200 Hilo, HI 96720

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## Home Health Hawai'i Island Referral Guide

Thank you for choosing our Home Health Services. Please fax to 808-800-2209 once completed. Feel free to contact us with any questions or inquiries.

**Documents/Information Required**

- ☑ Demographic Sheet
- ☑ Completed Referral Order Form (signed by a PHYSICIAN)
- ☑ Physician's most current visit note
    - This is the face-to-face encounter of the physician with the patient- must be within 90 days.
    - Document must state reason for Home Health Services.
    - **Document must state the reason/s why patient is homebound.**
    - Document must be completed and signed.
- ☑ Current Medication List
- ☑ Other pertinent documents necessary to support patient's eligibility for home health services:
    - History and Physical
    - Discharge summary and instruction (if applicable)
    - Advanced Health Care Directive / Provider Order for Life Sustaining Treatment
    - Therapy documents

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| PATIENT: | DOB: |
|---|---|

## Referral Order for Home Health Services

Primary Diagnosis for Home Health Services (***symptom diagnosis not permitted***):

I certify that my clinical findings support that this patient is homebound *(See patient's file for supporting documentation)*. I certify that, based on my findings, the following home health services are medically necessary for this patient:

- ☐ Skilled Nursing Evaluation and Treatment
  - ☐ Direct Skilled Service for ____________________
  - ☐ Skilled training or education for ____________________
  - ☐ Complex wound assessment and care ____________________
  - ☐ Skilled assessment and observation ____________________
  - ☐ Management of new and changed medications ____________________
- ☐ Physical Therapy Evaluation and Treatment
  - ☐ Assessment of functional deficits and home safety evaluation
  - ☐ Restore joint function for post joint replacement patient
  - ☐ Gait and mobility training

**NOTE:** Patient **must** be under the care of a provider or non- provider practitioner.
This patient is under my care. I have established a plan of care and it will be reviewed by a provider periodically. I, or an allowed provider or non- provider practitioner who communicated findings to me, performed a face-to-face encounter. The encounter with the patient was in whole, or in part, for a medical condition which is the primary reason for home health care. *(See patient's file for supporting documentation).*

| Community Physician/PCP/NPP | Date of follow up appointment: |
|---|---|
| Physician/Nurse Practitioner Signature | Date: |
| Print Name/Facility | |