Catholic Home Care

Catholic Health Services

At the heart of health

PLEASE FAX REFERRALS TO
631-465-6855
or call
Physician Referral Hot Line
631-465-1800

Confidential Communication

The information contained in this transmittal may include privileged or confidential material intended solely for the individual to whom it is addressed. The material may also include information of a proprietary nature that is exempt from disclosure under applicable State and Federal laws. Such disclosure is expressly prohibited without the prior, written authorization of Catholic Home Care. If the recipient of this transmittal is not the intended person(s), you are notified that any unauthorized dissemination, distribution, or duplication of this material is strictly prohibited. If you have received this communication in error, please notify the sender immediately, and return the original communication to the address above by US Postal Service. The recipient of patient information is prohibited from disclosing the information to any other party and is required to destroy the information after the stated need has been fulfilled."

Patient's Name: _____

Address: _____ City: _____ Zip: _____

Patient's Phone: _____ Date of Birth: _____ Gender: ( ) Male ( ) Female

Emergency Contact Person Outside the Home: (Name/#): _____

Insurance Name: _____Policy #_____

Insurance Name: _____Policy #_____

Diagnosis: 1. _____

2._____

Past Medical History: _____

_____

☐RN Evaluation for Home Care ☐Behavioral Health ☐Infusion ☐Wound Care

☐Physical Therapy ☐Occupational Therapy ☐Speech Language Pathology ☐Medical Social Worker

Special Instructions: _____

_____

Please attach CURRENT MEDICATION RECORD AND LAST PHYSICIAN OFFICE VISIT NOTE

Face to Face Encounter Certification

I certify that a Medicare enrolled physician or a non-physician practitioner performed a face to face encounter on the above patient **on _____.**

The clinical findings of this encounter support that the patient is homebound and in need of intermittent **Skilled Nursing and/or therapy (Physical Therapy or Speech Language Pathology)** and are documented below.

_____

_____

_____

Dr. Name's: (printed)_____

Address: _____

Phone: _____

License: _____ NPI #: _____

Doctor Signature: _____ Date: _____