VERGE HOME CARE

INITIAL PATIENT REFERRAL FORM

4622 S. Closner Blvd., Edinburg TX 78539

TEL (956) 287– 7575   FAX (956) 287 – 7979

PATIENT INFORMATION

Patient Name:				**Date of Birth:**	
Address:					
City:		**Zip:**		☐ **Male**	☐ **Female**
Phone Number:			**Cell Number:**		
Medicare #:			**Medicaid #**		

EMERGENCY CONTACT OR RELATIVE INFORMATION

Relative Name:		**Phone Number:**	

PHYSICIAN INFORMATION

Physician Name:					
Address:					
City:		**Zip:**		**Phone Number:**	

PHYSICIAN FACE TO FACE ATTESTATION – To be filled out by physician office

The encounter with the patient was in whole, or in part to the medical condition for which the patient needs home health services (list medical condition) : ____

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My clinical findings support the need for the requested home health services:__________________________

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I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face to face encounter that meet the physician face-to-face encounter requirements.

_______/______/______   (Date visit occurred)

I certify that based on my clinical findings, the following home health services are medically necessary for this patient (Mark all that apply)

Skilled Nurse   Therapy

I certify that my clinical findings support that this patient is homebound because: (i.e. needs assistance for all activities, residual weakness, requires max assistance/taxing effort to leave home, confusion/unsafe to go out of home alone, SOB/SOB upon exertion, unable to safely leave home unassisted and/or any other clinical findings that effect homebound status. Note that pt requires considerable or taxing effort to leave their residence for medical reasons and religious services or infrequent or of short duration for other reasons):

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M.D.	**Hospital ADM Date:**	**Hospital Discharge Date:**

On-Line Verification Date: ______________________ ☐ Inactive ☐ Active with __________________________	**Date Received**

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