Phone: 508-219-0101 / Fax: 508-281-2030 / Web: www.brocktonhha.com

Client Referral Form

Thank you for choosing to refer your patient to Brockton Home Health Care Agency.
To start the referral process, please fill out this form and fax it to our office, or you can visit us at our website!
Patient Information Referral Date:

Patient's full name	DOB:
Address:	
Town: State: MA Zip:	
Primary Phone: ( ) Secondary Phone: ( )	
Social Security #:	
Medicaid Number: Medicare Number:	
Guardian/Legal Representative (If applicable)	
Name: Phone: ( )	
REASON FOR REFERRAL (please circle all applicable)	
Patient's Diagnoses:	
o Skilled Nursing o Medication Management o Physical Therapy o Occupational Therapy o Home Health Aide	

Physician Signing Home Care Orders (Plan of Care)

Name:	NPI Number:
Address:	
Phone: ( ) Fax: ( )	
Physician Signature (If Applicable):	

Additional Physicians/Providers

For Office Use Only

Referral Source:	Verbal:	Eval:
Assigned MRN #:	F2F:	Med List:

Staff processing referral:	Admitting Nurse:	Admit Date:

Brockton Home Health Care Agency, LLC

"We're here for you"

Face to Face Encounter Verification

I had a face to face encounter with_____

_____

patient on this date __ _____ (All patients needing Medicare reimbursed home health care services are required to have a documented face to face encounter with an eligible health care provider within the 90 day period before or 30 days after the initiation of needed home health care services.)

The following services are medically necessary home health care services:

_____Skilled Nursing
_____Physical Therapy
_____Speech Therapy
_____Occupational Therapy

Certification of Homebound Status:
My clinical findings from this encounter support the patient is homebound due to:

_____Leaving home requires a considerable and taxing effort

_____Absences from home are infrequent, of short duration or to receive healthcare treatment

_____Medically restricted due to immunosuppression, infectious illness, risk of infection or injury, or

_____

_____ _____

Physician Signature **Date**

Please return this completed document to:

Brockton Home Health Care Agency, LLC
71 Legion Parkway Suite 20
Brockton, MA 02301
(508) 219-0101
(508) 281-2030