island health care island hospice THAGroup independent life at home ideal aging

PHYSICIAN REFERRAL FORM

Patient Name: _____ **DOB:** _____

PATIENT IS BEING REFERRED FOR THE FOLLOWING SERVICES:

Check all that apply.

☐ **Island Health Care** ☐ RN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA ☐ Telemonitoring

Special Instructions: _____

_____

☐ **Island Hospice (nonprofit)** ☐ GIP ☐ Routine Home Care

☐ **Independent Life at Home** Non-medical life care assistance services – based on individual needs

☐ **Ideal Aging** Geriatric care management, assistance with aging in place

☐ **RightHealth®** ☐ RN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA ☐ Telemonitoring

Special Instructions: _____

_____

☐ **Specialty Programs** ☐ Palliation

Please include the following so we may properly process your referral:

☐ Patient demographics and insurance information (face sheet) ☐ Last visit note ☐ Medication list

FACE TO FACE ENCOUNTER DOCUMENTATION

Required for Island Health Care referrals.

I or a non-physician practitioner working with me had a face to face encounter with this patient on _____,
Date

during which his/her medical condition was addressed. The following clinical findings support the need for skilled services:

_____

_____

The following clinical findings support that this patient is homebound*:

_____

_____

*Absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons.

Physician Printed Name: _____ Date of Signature: _____

Physician Signature: _____

Please fax this form to 888-842-3293. Call 888-842-4663 if you have any questions.