One Good Home Health, Inc.
3148 W. Willow Ave, Clovis Ca 93612
Office: (559)388-8633
Fax: (559)878-4029

Patient Referral Form/ Face-to-Face Encounter Form

Patient Name: _____ (Optional Write in Name and attach demographic Sheet)

Address: _____

Phone/Cell: _____ **DOB:** _____ **SSN#**_____

Insurance: Name _____ **Policy#**_____

****** Please provide History & Physical and Medication List with this form. ******

F2F Encounter Date: _____. Primary reason for home health care: _____

My clinical Findings support that this patient is homebound and meets the need for below services because:

_____

HOME HEALTH ORDERS

____ Skilled Nursing ____ Physical Therapy ____ Occupational Therapy ____ Speech Therapy

____ Medical Social Work ____ Home Health Aide

SPECIALTY PROGRAM

____ Stoker Care ____ Cardiac Care ____ Neurological disease ALS/Parkinson's/MD ____ COPD

____ Orthopedic/Joint Replacement

Additional Orders and/or Diagnosis:

_____

_____

_____

Physician Signature: _____ **Date:** _____

Physician's Printed Name: _____**Phone:** _____

Address: _____ **Fax:** _____