MUSC Health
Medical University of South Carolina
AT HOME by BAYADA

HOME HEALTH CARE REFERRAL ORDER FORM

Client Name: ______________________ DOB: __________ Referral Date: __________

Medicare#/Insurance: ______________________________

Referral Source: ☐ Community ☐ Institution Name: ______________________

HOME HEALTH FACE TO FACE DOCUMENTATION		
Date of F2F Encounter:	Diagnosis related to Home Health Care:	
REFERRAL ORDERS		
☐ **SN** ☐ Medication Assessment/Education ☐ Wound Care ☐ New Ostomy/Colostomy ☐ Observation and assessment/teaching and training of new or exacerbated condition ☐ Other:		☐ **ST** ☐ Dysphagia ☐ Speech/Language ☐ Other:
☐ **PT** ☐ Gait/Balance ☐ Therapeutic exercises/activity ☐ Restore client's function ☐ Other:	☐ **OT** ☐ ADLs/IADLs ☐ Therapeutic exercises/activity ☐ Other:	☐ Other Disciplines:

IMPAIRMENTS/LIMITATIONS THAT SUPPORT HOMEBOUND STATUS AND NEED FOR SKILLED CARE		
Impaired Structure	**Impaired Functions**	**Activity Limitations**
☐ Brain, spinal cord, or related ☐ Cardiovascular system ☐ Respiratory system ☐ Urinary system or pelvic floor ☐ Head and neck region ☐ Eyes, ears, nose, mouth or throat ☐ Upper extremity or shoulder ☐ Lower extremity ☐ Trunk ☐ Structures related to movement ☐ Skin ☐ Other:	☐ Orientation, memory, attention ☐ Emotional functions ☐ Seeing ☐ Hearing ☐ Sensory, touch, proprioceptive ☐ Pain ☐ Heart functions ☐ Respiratory functions ☐ Exercise/activity tolerance ☐ Urination/defecation ☐ Mobility or stability of joints ☐ Muscle tone or power ☐ Gait function ☐ Other:	☐ Carrying out daily routine ☐ Acquiring skills (learning) ☐ Communication (expressive) ☐ Communication (receptive) ☐ Speaking ☐ Changing/maintaining body position ☐ Transferring oneself ☐ Hand and arm use ☐ Self-care and washing oneself ☐ Toileting ☐ Dressing ☐ Eating or drinking ☐ IADLs ☐ Other:

HOMEBOUND STATUS
☐ Patient requires assistance and/or the following assistive device:
☐ Patient is medically restricted to the home due to:

Please fax this form to: ______________________ and include the following:

1. F2F Clinical encounter note and H&P or Discharge Summary
2. Current Patient Demographics and Medication List
3. Pertinent Medical Records

______________________ ______________ ______________
Physician Signature Date Time

PECOS Enrolled: ☐ Yes ☐ No

____
Physician Printed Name