Home Health Honolulu
2228 Liliha Street, #205
Honolulu, HI 96817
Phone: (808) 531-0050

FACSIMILE TRANSMITTAL

TO: Dr.	**Fax #:**
FROM:	**Fax #:** 808-800-2209
PAGES: 3 page(s) including cover page	**Date:**
RE: Patient-	

Aloha Provider,

Please review home health service request and kindly respond. If anyone has questions please call our office at 808-531-0050.

Mahalo,
Marita Toledo RN/Patient Care Coordinator
p: 808.531.0050 | f: 808.800.2209
a:2228 Liliha Street,#205 Honolulu, HI 96817

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2228 Liliha Street, #205 Honolulu, HI 96817

Telephone: 808-531-0050

Fax: 808-800-2209

Home Health Honolulu Referral Guide

Thank you for choosing our Home Health Services. Please fax to 808-800-2209 once completed. Feel free to contact us with any questions or inquiries.

Documents/Information Required

- ☑ Demographic Sheet
- ☑ Completed Referral Order Form (signed by a PHYSICIAN)
- ☑ Physician's most current visit note
  - This is the face-to-face encounter of the physician with the patient- must be within 90 days.
  - Document must state reason for Home Health Services.
  - **Document must state the reason/s why patient is homebound.**
  - Document must be completed and signed.
- ☑ Current Medication List
- ☑ Other pertinent documents necessary to support patient's eligibility for home health services:
  - History and Physical
  - Discharge summary and instruction (if applicable)
  - Advanced Health Care Directive / Provider Order for Life Sustaining Treatment
  - Therapy documents

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PATIENT:	DOB:

Referral Order for Home Health Services

Primary Diagnosis for Home Health Services (***symptom diagnosis not permitted***):

I certify that my clinical findings support that this patient is homebound *(See patient's file for supporting documentation)*. I certify that, based on my findings, the following home health services are medically necessary for this patient:

- ☐ Skilled Nursing Evaluation and Treatment
  - ☐ Direct Skilled Service for ______________________________
  - ☐ Skilled training or education for ______________________________
  - ☐ Complex wound assessment and care ______________________________
  - ☐ Skilled assessment and observation ______________________________
  - ☐ Management of new and changed medications ______________________________
- ☐ Physical Therapy Evaluation and Treatment
  - ☐ Assessment of functional deficits and home safety evaluation
  - ☐ Restore joint function for post joint replacement patient
  - ☐ Gait and mobility training
- ☐ Occupational Therapy Evaluation and Treatment
  - ☐ Assessment of functional deficits and home safety evaluation
  - ☐ ADL training
- ☐ Speech Language Pathology Evaluation and Treatment
  - ☐ Improve swallowing
  - ☐ Improve speech, language, and voice function
  - ☐ Improve cognitive function

Other: ______________________________

NOTE: Patient **must** be under the care of a provider or non- provider practitioner.
This patient is under my care. I have established a plan of care and it will be reviewed by a provider periodically. I, or an allowed provider or non- provider practitioner who communicated findings to me, performed a face-to-face encounter. The encounter with the patient was in whole, or in part, for a medical condition which is the primary reason for home health care. *(See patient's file for supporting documentation).*

Community Physician/PCP/NPP	Date of follow up appointment:
Physician/Nurse Practitioner Signature	Date:
Print Name/Facility	