Home Health Kauai
3-3367 Kuhio Highway
Lihue, HI 96766
Ph: 808-245-5121 Fax: 808-800-2198

FACSIMILE TRANSMITTAL

TO: Dr.	**Fax #:**
FROM:	**Fax #:** 808-800-2198
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 808-245-5121.

Mahalo,
Matthew "Zack" Canada RN/Patient Care Coordinator
p: 808. 852-0560 | f: 808.800-2198 | c: 808-852-0560
a:3-3367 Kuhio Highway Lihue, HI 96766

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Home Health Kauai Referral Guide

Thank you for choosing our Home Health Services. Please fax to 808-800-2198 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

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	