

Home Health Maui
1520 Lower Main Street
Wailuku, HI 96793
Ph: 808-244-3661 Fax: 808-244-5470
www.ohanapacific.com/home-health-maui



FACSIMILE TRANSMITTAL

TO: Dr .	Fax #:
FROM:	Fax #: 808-244-5470
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, Sara Lutey RN/Patient Care Coordinator p: 808. 562-3717 f: 808.244-5470 c: 808-562-3717 a:1520 Lower Main Street Wailuku, HI 96793	
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Home Health Maui 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