PATIENT REFERRAL FORM

LAWRENCE COMMUNITY HEALTH SERVICES
LAWRENCE HOME CARE OF WESTCHESTER
JANSEN HOSPICE AND PALLIATIVE CARE
THE BEREAVEMENT CENTER OF WESTCHESTER

INSTRUCTIONS

Thank you for choosing Lawrence Homecare of Westchester *(Certified home health agency)* or Jansen Hospice and Palliative Care. In the spaces below, indicate patient and physician information. To process the patient's referral efficiently please utilize the checklist below and forward all the necessary documentation in one batch via email or fax.

Referral to: ☐ Jansen Hospice and Palliative Care Fax: 914-725-6381 ☐ Lawrence Homecare of Westchester Fax: 914-725-6384

PRACTICE/PROVIDER INFORMATION

Provider Name		Street Address, City, State, zip code	
Telephone		Fax	
Office Email Address		NPI Number & License Number	

PATIENT AND CAREGIVER INFORMATION

Patient Legal Name		Street Address, City, State, zip code	
Date of Birth		Insurance Information	
Email Address		Telephone number	
Caregiver Name		Caregiver telephone number	

PATIENT DIAGNOSIS

Primary Diagnosis		Secondary diagnosis	
Reason for referral			

DOCUMENT CHECKLIST

- ☐ Patient's Face sheet *(which **includes insurance information**)*
- ☐ MD Order indicating "*patient referred for homecare for skilled services such as (RN,PT,OT,ST,MSW)*" (Homecare only)
- ☐ Attached Certificate of Terminal Illness (CTI) signed and completed (Hospice only)
- ☐ Patient's most recent provider note and past medical history
- ☐ Patients current med list
- ☐ Attached Face to Face completed (Homecare only)

Send documents either by fax or email to:

Jansen Hospice and Palliative Care Fax: 914-725-6381 dob9057@nyp.org; pec9047@nyp.org

Lawrence Homecare of Westchester Fax: 914-725-6384 def9064@nyp.org; brm9213@nyp.org

NewYork-Presbyterian
Lawrence Home Care
of Westchester

Lawrence Home Care of Westchester
NewYork-Presbyterian

Tel 914-787-6158 Fax 914-725-6384

Certification of Face to Face Encounter

Patient Name: ___ _____

In order to comply with the Center for Medicare and Medicaid Services (CMS) I understand the requirements and responsibilities for the physician documentation of the patient's eligibility for Home Health Services. I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: _____

Attached is my visit note which includes the patient's Primary diagnosis, the reason for home care services and my clinical findings to support the need for services as well as evidence that the patient is Homebound. Also, I have discussed Home Care Services with the patient and /or family.
The encounter with the patient was in whole, or in part, related to the primary reason the patient requires Home Health Services. **(Attach Clinical Office Note to support the F2F)**
(Add an Addendum to clinical note if there was a change in patient's status since office visit)
I certify that, based on my findings, the following services are medically necessary home health services (check all that apply): _____Nursing _____PT _____SLP _____ OT
To provide the following care/treatments:

_____ Medication Teaching and monitoring
_____ Observation and Assessment
_____ Wound care, catheter care, ostomy care
_____ Physical Therapy evaluation
_____ Other _____

My clinical findings that support the need for the above services <u>because:</u>

_____ Recent hospitalization for _____
_____ New onset or acute exacerbation of diagnosis _____
_____ New and/or changed prescription medication
_____ Acute change in condition (weight gain, increased SOB, increased weakness, other)
_____ Complicating factors (wound care for a diabetic with peripheral angiopathy)
_____ Need for foley/suprapubic catheter changes
_____ Other _____

I certify that my clinical findings support that this patient is homebound. There exists a normal <u>inability</u> for this patient to leave home due to this recent change in status and leaving home requires <u>considerable</u> and <u>taxing</u> effort. Leaving home also exacerbates symptoms (e.g. shortness of breath, pain, anxiety, confusion, fatigue). Additionally the patient is Homebound due to their need for the assistance of a device and /or another person to safely leave their home.

___ Because of patient's current condition, leaving home is medically contraindicated.

Physician Signature _____Date_____

Printed Physician Name_____ NPI#_____

PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS

CERTIFICATION STATEMENT (FIRST 90-DAY PERIOD) _____
Dates of Service

WE (OR I) CERTIFY THAT _____IS TERMINALLY ILL WITH A LIFE EXPECTANCY OF SIX (6) MONTHS OR LESS BASED ON THE EXPECTED COURSE OF THE DISEASE.

_____ _____
Certification Date Angel Rodriguez, MD, Medical Director Date

_____
Attending Physician Date

VERBAL CERTIFICATION OF TERMINAL ILLNESS RECEIVED FROM MD

_____
Signature /Date

OR (check when appropriate)

_____PATTIENT HAS NO ATTENDING PHYSICIAN AND IS RELYING ON THE HOSPICE TO FULFILL MAJOR ROLE IN DETERMINING AND DELIVERING CARE.