

# FAST TRACK REFERRAL FORM

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics / face sheet) and office visit note to: (877) 288-7168.

<b>PATIENT</b>	Patient Name: _____	SSN: _____
	Date of Birth: _____ <input type="checkbox"/> M <input type="checkbox"/> F	Address: _____
	Phone: _____	City, State, Zip: _____
	Alternate Contact Name: _____	Last Flu Vaccine Date: _____
	Alternate Contact's Number: _____	Referral Date: _____
Primary Care Physician: _____	Insurance Information: _____ <i>(or attach copy)</i>	

Office Contact Name: \_\_\_\_\_ Office Contact Number: \_\_\_\_\_

DIAGNOSIS / MEDICAL CONDITION: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

HgbA1C Date: \_\_\_\_\_ HgbA1C Result: \_\_\_\_\_

SKILLED SERVICES / INTERVENTIONS: *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

- Skilled Nursing for: \_\_\_\_\_  Occupational Therapy: \_\_\_\_\_
- Physical Therapy for: \_\_\_\_\_  Social Work: \_\_\_\_\_
- Speech Therapy for: \_\_\_\_\_  Home Health Aide: \_\_\_\_\_

ADDITIONAL ORDERS: \_\_\_\_\_

## CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Signature Date: \_\_\_\_\_

## OPTIONAL PHYSICIAN DOCUMENTATION

*This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.*

CLINICAL FINDINGS: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*

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