Sunshine
SUNSHINE HOME HEALTH II, INC.

4637 Chabot Dr., Suite 240,
Pleasanton, CA 94588
Phone: (925) 469-1000
Fax: (925) 469-1001

REFERRAL FORM - HOME HEALTH SERVICES

PATIENT INFORMATION:

Name: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

SSN: _____ DOB: ____/____/____ Age: _____ Sex: Male☐ Female☐

Emergency Contact: _____ Emergency Contact Number: _____-_____-_____

PAYOR INFORMATION:

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

DATE OF FACE-TO-FACE ENCOUNTER: _____/_____/_____

SKILLED HOME HEALTH SERVICE ORDERS AND MEDICAL NEEDS:

☐ Skilled Nursing needed for_____

☐ Physical Therapy needed for_____

☐ Occupational Therapy needed for_____

☐ Speech Therapy_____

☐ Medical Social Worker_____

MEDICAL CONDITIONS *(That are the primary reasons for this encounter and home health services)*

- _____ _____
- _____ _____
- _____ _____

RECENT HOSPITALIZATION: _____ Date:_____

HOMEBOUND STATUS

The patient is considered to be homebound as the following Medicare criteria are met:

1) Departures from the home are medically contraindicated secondary to increased risk for exacerbation of medical condition due to _____.

2) Departures from home require the assistance of another person.

3) Patient has a normal inability to leave home and doing so requires considerable and taxing effort as a result of _____

I certify this patient is under my care, that I (or a nurse practitioner or physician's assistant working with me) had a face-to-face encounter with the patient; and that clinical findings support the aforementioned services are medically necessary and the patient is homebound.

Physician Printed Name:_____ NPI: _____

Phone #:_____Fax #:_____

Physician Signature: _____ Date: _____