REFERRAL FORM

12815 Northline Southgate, MI 48195 Phone (734) 324-3166 Fax (866) 422-4071
Website: axiomcaresmi.com E-mail: info@axiomcaresmi.com

☐ **HOME CARE REFERRAL** ☐ **HOSPICE REFERRAL** ☐ **PALLIATIVE CARE REFERRAL**

*** Palliative patient needs pain & symptom relief from illness not determined to cause a 6 month or less condition decline prognosis*

Patient Name DOB: / /	**PATIENT INSURANCE**
Last: First:	Medicare #:
Patient Address:	Medicare Advantage #:
City State: Zip:	Other Coverage:
Home Phone: Cell Phone:	
Language Spoken:	Auth#
____ Married _____ Single _____ Divorced _____ Widowed	**REFERRING PHYSICIAN**
____ *Lives Alone* ____ *Lives w/Spouse* *Other*___________________	Dr:
Emergency Contact:	NPI:
Relationship to patient:	Phone:
Phone Number:	Fax:
CARE PLAN OVERSIGHT	Address:
Will the Referring Physician oversee and sign all Orders?	
☐ Yes ☐ No If No, following Physician to oversee care is:	
Dr:	*Authorizing provider must be PECOS Registered*
HOME CARE	**HOSPICE**
Choose one of the following orders for SOC date:	*Choose one of the following orders for SOC date:*
☐ SOC on a specific date: / /	☐ URGENT - SOC within 24 hours of referral
☐ SOC within 24-48 hours of referral	☐ SOC on a specific date: / /
Is Patient competnent to sign consents?__________	** *Is family aware of Hospice referral?* _____________
Following skilled services are necessary on an intermittant basis:	Is Patient competnent to sign consents?____________
☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy	☐ Mediport Access ☐ IV
☐ Speech Therapy ☐ Home Health Aide ☐ Social Worker	Terminal Diagnosis:

FACE-TO-FACE ENCOUNTER CERTIFICATION

DATE OF PHYSICIAN/PATIENT ENCOUNTER:______________/________________/________________

** encounter must be within 90 days before or 30 days after date of referral AND related to primary reason for services*

MEDICAL REASON(S) FOR ENCOUNTER (diagnosis): ____

CLINICAL FINDINGS(reason for disciplines): ____

REASON(S) PATIENT IS HOMEBOUND (example: patient is unable to leave home unassisted, leaving home requires taxing effort):

****** ***Please include most recent office or telehealth visit note when sending referral*** ******

CERTIFYING PHYSICIAN/NP/PA (printed name):	☐ **MD/DO** ☐ **PA** ☐ **NP**
PHYSICIAN * Must be signed by MD, DO, PA or NP who performed Encounter	**DATE:** / /

I certify that this patient is confined to his/her home and needs intermittent skilled care. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan.I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.