HEART HOME HEALTH CARE, INC

7545 South Freeway
Houston, Texas 77021
Tel: 713.654.8825 Fax: 713.571.6040

HOME HEALTH REFERRAL / ORDER

PATIENT NAME: _____ **PATIENT MEDICARE #:** _____

ADDRESS: _____

DATE OF BIRTH: ____/____/____ (MM/DD/YY) **AGE:** _____ **SEX:** F **TEL. #:** _____

CONTACT PERSON: _____ **TEL. #:** _____

DIAGNOSIS / CONDITION: _____

HOSPITAL / NURSING FACILITY: _____

HOSPITAL ADMISSION DATE: ____/____/____ (MM/DD/YY) **HOSPITAL DISCHARGE DATE:** ____/____/____ (MM/DD/YY)

REFERRAL SOURCE: CARL JENKINS

PHYSICIAN NAME: DR. JAMES WATSON **TEL. #:** 713-520-8963 **FAX:** 713-523-6941

MD UPIN #: _____ **Tax ID #:** _____ **N.P.I. #:** _____

ORDERS: ***SN TO ASSESS AND EVALUATE FOR HOME HEALTH CARE SERVICES***

☑ **SN** ☐ **PT** ☐ **OT** ☐ **ST** ☐ **MSW** ☐ **HHA** ☐ **NUTRITIONIST**

MEDICATIONS: _____

RN SIGNATURE: _____ **DATE:** 12 / ____ / 2007 (MM / DD / YEAR)

MD SIGNATURE: SEE ATTACHED ORDERS **DATE:** 12 / ____ / 2007 (MM / DD / YEAR)

FOR HEART HOME HEALTH CARE USE ONLY

PATIENT SOCIAL SECURITY #: _____ **MEDICAID #:** _____

SECONDARY INSURANCE: _____

MEDICAL RECORD #: _____

☑ **Patient was reffered to Heart Home Health for Home Services on the following date:** 12 / ____ / 2007 (MM / DD / YEAR)

☐ **Patient was not admitted to Heart Home Health for Home Services due to the following:** _____

_____

HEART HOME HEALTH CARE, INC.
7405 ALMEDA RD. SUITE B.
HOUSTON, TEXAS 77054

REFERRAL TRACKING FORM

PATIENT NAME: _____

DATE OF REFERRAL: _____/____/_____

ADDRESS CONFIRMATION: _____

_____

REFERRING PHYSICIAN: _____

DATE PATIENT / FAMILY CONTACTED: _____

INFORMED OF ADMIT DATE: _____

NAME OF ADMITTING RN: _____

ADMIT ☐YES ☐NO

ADMIT DATE: _____ _____
RERERRED ADMITTED

NAME OF ADMITTING PT: _____

ADMIT ☐YES ☐NO

ADMIT DATE: _____ _____
RERERRED ADMITTED

PATIENT PHYSICIAN CONTACTED: _____

COMMENTS / CORRESPONDENCE: _____
WHY NON-ADMIT _____
WHY LATE ADMIT _____
_____
_____
_____
_____
_____
_____

120 Days: _____
Loc: _____

OASIS TRACKING

☑SOC ☐ROC ☐RC/Follow-up ☐DC ☐Transfer ☐Death ☐Intra Agency Transfer

Date: 12 / /		
Patient:	Episode From:	Through:
☐Medicare ☐Medicaid ☐Insurance ☐Other	SOC Date:	
Admission Source: ☐Physician (1) ☐Clinic (2) ☐HMO(3) ☐Hospital (4) ☐SNF (5) ☐other HC facility (Rehab,NH) (6) ☐ER (7) ☐Not Available (9) ☐From Other HHA (B) ☐Readmit (c)		
Was SOC Preformed within 48 hours of referral?	☐YES ☑NO ☐N/A	
If not. Is the verbal order included in the chart?	☐YES ☑N/A	
Is new 485 required? (SOC, Recert only)	☐YES ☐NO	

PROCESS	DATE	SIGNATURE
Medicare On-Line Verification		
OASIS Assessment received/submitted		
Audited/HHRG hand tool/kinnser		
OASIS data audited for accuracy/logic, etc.		
Actual MOO90/approval		
485 Data entry completed (if applicable)		
Encoding entry completed/checked ☐N/A		
Final Audit		
Pre-Flight Checklist/Kinnser		
Locked		
485 Release date		
Logged/Mailed/Delivered		

RAP-HHRG

Verified SOC/Recert RAP Checklist		
Episode Created/OASIS Attached		
Branch: Parent Billing Notified		☐N/A
Run Missed Encounter Report		
Parent: RAP to FMS		

Date Rap Paid: _____ Amount Paid: $ _____

EOE- HHRG:

Verified EOE Checklist		
Run Calendar/Supply itemization/check increments		
Verify visits/supply (Date 1st Billable visit: _____)		
Verify receipt of Orders		
Create/Confirm EOE (Date Last Billable visit: _____)		
Attach OASIS (I.e. SCIC)		☐N/A
Verify OASIS accepted by State		
Branch: Parent Billing Notified		☐N/A
Parent: Run Account History Report		
Parent: EOE/Final Claim submitted to FMS		

Date Claim Paid: _____ Amount Paid: $ _____

Note: If you do not meet OASIS timeframes, you MUST document reasons in the OASIS Log.

♥HEART HOME HEALTH CARE, INC.♥

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THERAPY SERVICE HOME HEALTH REFERRAL

PLEASE CHECK SERVICE REQUESTING:

☑ **PT** ☐ **OT** ☐ **SLP** ☐ **IV** ☐ **RESP/DME** ☐ **NUTRITIONIST**

Cert Period: (/ / --- / /)

HIPPA COMPLIANCE

Has this patient given consent for PHI to be disclosed for treatment, operations, and payment ? ☐ **YES**

Has this received notice of the privacy practices? ☐ **YES**

Patient Name:

Address:

Telephone # :

Date of Birth: / / Age: Sex: *F*

Patient HIC #:

Secondary Ins: N/A

Next of Kin Emergency Contact:

Telephone #:

Hospital Admission Date: N/A Discharge Date: N/A

Referring Physician: *DR. JAMES WATSON*

Telephone #: *713-520-8963*

Diagnosis: 1. 3.
2. 4.

ORDERS: ☐ **PT** ☐ **OT** ☐ **SLP** ☐ **IV** ☐ **RESP/DME** ☐ **NUTRITIONIST**

Medications:

Equipment:

Comments:

Evaluating Nurse:

RN Signature: Date: / /