INTAKE REFERRAL FORM - PDGM

Date of Referral:_____

DEMOGRAPHICS

Patient's Name:_____ DOB:_____ Age:_____ Gender: ❍ Male ❍ Female
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ ❑ Alternate Phone:_____ Email:_____
Marital Status: ❍ Married ❍ Single ❍ Widowed ❍ Divorced
Primary Language:_____ ❑ Language Barrier ❑ Needs Interpreter ❑ Other:_____

INSURANCE

Medicare #:_____ Medicaid #:_____
Secondary Payer:_____ ID #:_____
MCR Advantage Plan:_____ MCR Advantage #:_____ Auth Required: ❍ Yes ❍ No
Reimbursement is ❍ Episodic ❍ Pay per visit
❍ New Patient ID #:_____ ❍ Former Patient ID #:_____
Eligibility Checked by:_____ Date:_____

EMERGENCY CONTACT

Emergency Contact:_____ Relationship:_____
Phone:_____ Email:_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Language:_____ ❍ Needs Interpreter ❍ Other:_____
Legal Representative:_____ Type:_____ Phone:_____
Primary Language:_____ ❍ Needs Interpreter ❍ Other:_____

REFERRAL SOURCE

Referral Source:_____ Phone:_____
Discharge Facility:_____ Phone:_____
Discharge Date:_____ Admission Source: ❍ Community ❍ Institutional Episode Timing: ❍ Early ❍ Late
Was the discharging facility a VA hospital: ❍ No ❍ Yes
Referring Physician:_____ NPI #:_____ Phone:_____
Certifying Physician (if different):_____ NPI #:_____ Phone:_____
If the patient was hospitalized, what was the primary discharge diagnosis:_____
Does the patient have a history of being hospitalized for this condition: ❍ No ❍ Yes ❍ Unknown
Does the patient have advance directives: ❍ No ❍ Yes ❑ Copy obtained Code status:_____

DIAGNOSES / F2F

Primary diagnosis, should indicate etiology, from referring physician:_____
Recent procedures or injury associated with primary diagnosis:_____
Pertinent secondary co-morbidities known:_____
_____
F2F Encounter Date:_____ Performed by: ❍ Physician ❍ Non-physician practitioner within 90 day of SOC
Provider Name:_____ NPI #:_____ Phone:_____
F2F scheduled within 30 days post SOC. Visit date scheduled for:_____
To be performed by:_____

SERVICES ORDERED

SN:_____ ST:_____
PT:_____ MSW:_____
OT:_____ AIDE:_____
Special Needs or Treatments:_____
_____
_____

❍ Not Admitted Reason (specify):_____
Date of Referral Accepted:_____ Date of Admission:_____ Physician Order SOC Date:_____
❍ New patient ID #:_____ ❍ Former patient ID #:_____
Assigned to:_____

Signature of person completing referral:_____ Date:_____

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List of Suggested Documentation from Referral Source - Acute/Post-acute Provider - complete per agency policy			
Documentation	**Received**	**Needed**	**Result of Follow-up/Query**
H&P			
Home Health Order			
Discharge Medication List			
Admission Summary			
Discharge Summary with Discharge Diagnosis			
Operative Report			
Progress/Clinical Notes			
Consultation(s) Report(s)			
Physician Visit Notes			
Pertinent Labs			
❑ PT ❑ OT ❑ ST Eval with Discharge Recommendations			
Pertinent X-rays			
Misc. Reports			
Other			

Checklist/Review of Significant Information and/or actions to complete a valid referral - complete per agency policy		
Information	**Complete**	**Comments**
Called responsible party to verify correct name, address and contact information for patient		
Verified patient's new Medicare Beneficiary Identifier		
Verified patient has a primary caregiver		
Verified patient has a representative and type		
Verified emergency contact info is correct		
Called certifying physician's office and had a two-way communication		
Verified certifying physician's name and contact information		
Verified and/or queried primary diagnosis (ICD-10 code) is acceptable for PDGM		
Verified all pertinent secondary co-morbidities		
Verified F2F documentation from the relevant provider's medical records is sufficient to demonstrate the patient's eligibility for Home Health services. F2F is acceptable to certifying physician if not provided by certifying physician.		
Verified physician order signed and dated to start home health		
Verify insurance/eligibility		
Verified and/or requested a copy of advance directives and code status as needed		