CORNERSTONE VNA
HOME • HEALTH • HOSPICE

Health Information Department
(formerly Intake Department)

Fax:
603-332-9223 or 877-234-9902

Phone:
800-691-1133 or 603-332-1133

Provider Practice Referral Form

Patient Name: _____ DOB: ____ / ____ / _____ ☐ Male ☐ Female

Information to be faxed with Referral: (or when it becomes available)

- ☐ Demographics/Insurance Info
- ☐ Address and phone number (where home health services provided if different than mailing address)
- ☐ Referring Provider
- ☐ Plan of Care Provider
- ☐ Recent progress notes pertaining to F2F encounter
- ☐ Office visit notes from two most recent visits
- ☐ COVID Status
- ☐ Most recent rehab notes
- ☐ Current Diagnoses List
- ☐ Current Medications List
- ☐ Next Scheduled Appointment Date and Provider Name _____
- ☐ Name and Contact Number of Patient's PCP _____

Referral Contact: _____ Phone Number: _____

"Face-to-Face Encounter" (F2F) Documentation for Medicare and Cornerstone VNA Patients

(Can be completed by MD, DO, nurse practitioner, clinical nurse specialist or physician's assistant does not have to be completed by PCP)

I, or a nurse practitioner, clinical nurse specialist or physician's assistant working with me, had a F2F encounter with this patient that addressed the primary reason for home health care.

1. Date of the F2F visit: _____ / _____ / _____ (must be within 90 days prior)
   Check one: Visit was completed ☐ In office OR ☐ Remotely via real-time, audio/visual technology
2. Medical diagnosis for home health services: _____
3. Skilled Service(s) Needed: _____
4. My clinical findings, noted below, support the need for the following home health services: (skilled service/task ordered)
   _____
   _____
   _____
5. Type of assistance required to leave home: _____
6. There is a normal inability and it is a taxing effort for the patient to leave home because:
   _____
   _____

I certify that the above stated patient is homebound and that upon completion of this Face-to-Face encounter has a need for intermittent skilled nursing, physical therapy and/or speech therapy or occupational therapy for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

Provider Signature: _____ Date: _____ / _____ / _____

Provider Name (Printed): _____

Thank you for your referral!