Gilead West Care Services Referral Form

Please complete this from and email it to *Info@gileadwestcare.com* Tel: (925) 208-9250

Home Health Referral

Referral Date: _____

We will see your patient within 48 hours unless a specific start of care date is provided here: _____

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ ☐ Male ☐ Female

Alternate Contact: _____ Contact #: _____ Relationship: _____

Payer: ☐ Medicare ☐ Insurance (Insurance Contact #): _____

☐ Medicaid ☐ Other: _____

HIC/ID#: _____ Policy #: _____ Group #: _____

Referring Primary Care Provider: _____ Phone: _____

Referring Facility: _____

Primary Care Provider for Home Health Orders: _____

Primary Care Provider Phone Number: _____

Diagnoses: _____

Face-to-Face Encounter

Visit within past 90 days: ☐ Yes ☐ No

Face-to-Face Encounter Date: _____

Please send the completed referral form and attach a copy of the Primary Care Provider's most recent signed and dated encounter with this patient which supports the reason for the ordered Home Health services. Examples may include: Primary Care Provider progress note, history and physical, discharge summary.

Order

Skilled Nursing for:

☐ Medication Management and Teaching ☐ Disease Management and Teaching

☐ Observation and Assessment of: _____

☐ Wound Care (Specify Below or Attach Orders): Location: _____ Frequency: _____

Clean w/: _____ Dress w/: _____

Pack w/: _____ Cover w/: _____

☐ Infusion (Attach Orders) ☐ Other (specify): _____

Physical Therapy for:

☐ Evaluation and Treatment ☐ Other (specify): _____

Occupational Therapy for:

☐ Evaluation and Treatment ☐ Other (specify): _____

Speech Therapy for:

☐ Evaluation and Treatment ☐ Other (specify): _____

Home Health Aide for:

☐ Personal Care/Assist with ADLs

Medical Social Worker for:

☐ Community Resources ☐ Long-Term Planning ☐ Other (specify): _____

Print Primary Care Provider's Name: _____

Primary Care Provider's Signature: _____ **Date:** _____