HOME HEALTH
BY HALE MAKUA

1520 Lower Main Street,
Wailuku, HI 96793
Telephone: 808-244-3661
Fax: 808-244-5470

We improve the well-being of those in our care through compassionate personalized health services in our home and yours

Aloha,

Thank you for choosing Hale Makua Home Health.

Attached is our referral packet.

Please fax to 808-244-5470 when completed.

Feel free to contact us for any questions or inquiries.

Thank you,

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Hale Makua Home Health Referral Packet

List of Required Items:

- ☐ Demographic Face Sheet with insurance information
- ☐ Initial certification form with Face to Face encounter date
- ☐ Physician's most current visit note
    - This is the face to face encounter of the physician with the patient- must be within 90 days before the start of care of HH services.
    - Note must state reason for Home Health services
    - Note must state reason/s why patient is homebound
- ☐ Current Medication List
- ☐ Other documents pertinent for Home Health Services

Patient Name:	DOB:

Order/Referral for Home Health Services

Home Health Eval and Treat. I certify that my clinical findings support that this patient is homebound. (See patient file for supporting documentation). I certify that, based on my findings, the following home health services are medically necessary for this patient:

☐ Skilled Nursing
- ☐Direct Skilled Service_____
- ☐Teaching and Training_____
- ☐Complex Wound Assessment and Care
- ☐Management of new/changed medications
- ☐Assessment and Observation_____
- ☐Other_____

☐Physical Therapy
- ☐Assessment of functional deficits and home safety evaluation
- ☐Therapeutic exercise
- ☐Restore joint function for post joint replacement patient
- ☐Gait Training
- ☐ADL Training

☐Speech Language Pathology
- ☐Therapeutic exercise to improve swallowing
- ☐Therapeutic exercise to improve language function
- ☐Therapeutic exercise to improve cognitive function

In addition to these qualifying services, the patient needs:

☐Occupational Therapy

☐Social Work

☐Home Health Aide

This patient is under my care. I have established a plan of care and it will be reviewed by a physician periodically. I, or an allowed physician or non-physician practitioner who communicated findings to me, performed a face to face encounter on ____/____/_____. The encounter with the patient was in whole, or in part, for a medical condition which is the primary reason for home health care. (See patient file for supporting documentation).

Community Based Physician Assuming Responsibility:

Medicare Enrolled Certifying **Physician** Signature. *NPP completion/signature not allowed*:	Date:

Medicare Enrolled Certifying **Physician** Printed Name and Facility: