HOME HEALTH
BY HALE MAKUA

1520 Lower Main Street,
Wailuku, HI 96793
Telephone: 808-244-3661
Fax: 808-442-0443

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 Home Health by Hale Makua.

Attached is the guide to referring your patient for home health services.

Please fax to 808-442-0443 when completed.

Feel free to contact us for any questions or inquiries.

Thank you,

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Hale Makua Home Health Referral Guide

Documents/Information Required

- ☐ Demographic Sheet
- ☐ Completed Initial Certification Form (signed by a PHYSICIAN)
- ☐ Physician's most current visit note
    - This is the face to face encounter of the physician with the patient- must be within 90 days.
    - Document must state reason for Home Health services
    - Document must state reason/s why patient is homebound
- ☐ Current Medication List
- ☐ Other pertinent documents necessary to support patient's eligibility for home health services:
    - History and Physical
    - Discharge summary and instruction (if applicable)
    - Advanced Health Care Directive / Provider Order for Life Sustaining Treatment
    - Therapy documents

FURTHER ACTION REQUIRED! Fax submission does not guarantee start-of-care. Please call to verify receipt and confirm start-of-care date.

Patient Name:	DOB:

Order/Referral for Home Health Services

Primary Diagnosis for Home Health Services (*symptom diagnosis not permitted*):_____

_____

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

☐Physical Therapy Eval and Treat
- ☐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 Eval and Treat
- ☐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 Eval and Treat

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 signature not permitted*:	Date:

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

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