Better Speech & Swallow Corp.

Rapid Referral Form

◆◆ *Fax referral form with a copy of the* ***Patient's Demographics*** *to:* ***301-845-2736*** ◆◆
Please attach a SIGNED Consent Form (Patient signs if legally competent – if not POA needs to sign)

PHYSICIAN'S ORDER FOR THERAPY SERVICES

Patient Name: _____ D.O.B. _____

Is the Patient Home Bound? ☐ Yes ☐ No

Diagnosis: _____
Service Requested: ☐ **S.L.P.**

RX:

Medicare Home Health *Face to Face Encounter* Certification

Date of **FACE to FACE ENCOUNTER:** _____
This patient has been seen during this hospitalization/skilled nursing facility admission/physician office visit for the following medical conditions:

_____

_____

This patient needs skilled home health services for:

_____

_____

I certify that my clinical findings support that this patient is homebound *(i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons)* because:

_____

_____

The information requested on this form is mandated by the Affordable Care Act, effective January 1, 2011. Home Care services cannot be provided to the patient without completion of this document. The Plan of Care (485) will be forwarded to the patient's primary physician for approval after services have commenced. A hospitalist or covering physician may certify home care even if they will not be caring for the patient after discharge.

Physician's Name: (printed)_____

***Physician's Signature*: _____ Date: _____**