MEMORIAL HERMANN Home Care

Memorial Hermann Home Care & Hospice Referral Order
Fax Referrals To: (713) 338-7371
Phone (713) 338-7300

Patient's Name _____ DOB _____

Address: _____ Primary Ins: _____

City: _____ State: _____ Zip: _____ Ins ID / Medicare # _____

Phone: _____ Cell: _____ Group #: _____ Secondary Ins: _____

Additional Contact Person: _____ Primary Diagnosis: _____

Phone: _____ Cell: _____ Secondary Diagnosis: _____

PLEASE ATTACH RECENT PHYSICIAN PROGRESS NOTE (WITHIN 90 DAYS) RELATED TO CLINICAL NEED FOR CARE AND ANY OTHER PERTINENT PAPERWORK

HOME CARE

EVALUATE AND TREAT THE ABOVE PATIENT

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

SPECIALTY PROGRAMS

☐ Orthopedic Program ☐ Wound Care (Specify): _____

Date of last MD encounter: _____

Clinical findings to support Home Healthcare: _____

_____

_____

• **Homebound because:** _____

_____

Qualifying Help: *Homebound definition- An individual shall be considered "confined to the home" (homebound) if the following two criteria are met:*
1. Criterion One: *The patient must either: Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence OR Have a condition such that leaving his or her home is medically contraindicated. If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.*
2. Criterion Two: *- There must exist a normal inability to leave home; AND - Leaving home must require a considerable and taxing effort. (Medicare Policy Manual, Chapter 7, section 30.1.1, Rev. 10438, effective 03-01-2020)*

HOSPICE

☐ **Hospice Evaluation and Treat -** Admit if appropriate

Admitting diagnosis: _____

Qualifying Help: *An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy could be six months or less if the illness runs its normal course. (Medicare Benefit Policy Manual, Chapter 9, section 10, 2010).*

HOME MEDICAL EQUIPMENT

For a complete list of Home Medical Equipment Services, please call 281.787.7550 or fax 281.784.7545

☐ AM ☐ PM

_____	_____	_____	_____	_____	_____
Signature	**Physician Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

Referral Date: _____ Start Date: _____ Completed by: _____

Address: _____ Contact Person: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

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