APEX
Home Health Care, Inc.
2607 W. 22nd Street, Suite #47
Oak Brook, IL 60523
Tel: 855-594-7050 Fax: 855 594-7051
www.apex-health.com info@apex-health.com

HOME HEALTH REFERRAL FORM

PATIENT INFORMATION

Last Name:	First Name:		Sex: □M□F
Address:		City:	State:
Zip Code:	Telephone#:		
Date of Birth:	Social Security#:	Language(s):	
Family contact/relationship:		Telephone#:	

INSURANCE INFORMATION

Medicare#:	Medicaid#:	Commercial Insurance:
Subscriber#:	Policy#:	Group#:

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name:		NPI#:
Telephone#:	Fax#:	Office Contact:

I certify that this patient is under my care and that, I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on: **Date of Visit:** _____

DIAGNOSES/ICD CODES

1. _____/_____ 2. _____/_____
3. _____/_____ 4. _____/_____
5. _____/_____ 6. _____/_____

HOME HEALTH SERVICES & MD ORDERS

□Skilled Nurse □Psych Nurse □WOCN
□Physical Therapy (_x/wk x_) □Occupational Therapy (_x/wk x_) □Speech-Language Pathologist (_x/wk x_)
□Medical Social Worker □Home Health Aide □Dietitian □Podiatrist
□Labs: _____ □Diagnostics: _____
□DME: _____ (please include written Rx) □Other: _____

Physician Signature: _____ Date signed: _____

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