Stillwater Medical
Home Health Services

Home Health Services Referral
PO Box 2408, Stillwater, OK 74076
405-624-6578
405-624-6590 (Fax)

Please CALL before FAXING

Physician Information	
Date:	
Referral Contact Name and Number:	
Referring Physician:	
Phone:	
Fax:	

Patient Information

Phone Number	Patient's Name Last First MI		
DOB	Gender ☐ Male ☐ Female	Emergency Contact & Number:	Relationship ☐ Legal Guardian ☐ POA ☐ N/A

Insurance Information	
Primary Ins. Name:	
Policy/Group Number:	
Secondary Ins. Name:	
Policy/Group Number:	

Patient Health Information	
Primary Care Physician:	
Primary Diagnosis:	

Skilled Service:
☐ Skilled Nursing
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy

Ancillary Discipline:
☐ Home Health Aide
☐ Social Services
☐ Dietician
******Must have skilled service need to have ancillary service under Medicare***

Please Send the following documents with this form:
☐ H&P/DC Summary/Most recent office visit note
☐ Documentation of Face to Face Encounter
☐ Copy of Ins. card if available
☐ Current Medication List
☐ Adv. Directive/DNR/POA/Guardianship if applicable

Any Specific Orders/Services to be Provided:

Face to Face Encounter
☐ Already Completed–sending document
☐ To Be Completed
Date & Time Schedule_____________

Must be within 30 day of Home Health Start Date

Physician's Signature ______________ Date ______________ Time ______________

Reviewed/Revised: 9/17 Reference: For Use On:	STILLWATER MEDICAL CENTER **Home Health Services Referral** Home Health	Pt Name:______________________ Acct #:______________________