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:	**Ancillary Discipline:**	**Please Send the following documents with this form:**
☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy	☐ Home Health Aide ☐ Social Services ☐ Dietician ******Must have skilled service need to have ancillary service under Medicare***	☐ 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 #:_____