Email : info@cchh08.com Phone : (805)543-2244 Fax : (805)543

YOUR CHOICE FOR LOCAL HOME HEALTH SERVICES

START OF CARE ORDERS

Physcian: _____

Patients Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ SSN: _____

Allergies: _____

INSURANCE INFORMATION

☐ Medicare ☐ Other _____ ID# _____

I CERTIFY THAT, BASED ON FINDINGS, THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY (check all that apply):

Skilled Nursing
- ☐ Medication Management
- ☐ Pain Management
- ☐ Cardiac Care
- ☐ Diabetic Management
- ☐ Respiratory
- ☐ Other:_____

Physical Therapy
- ☐ Weakness
- ☐ Ambulation/Gait Training
- ☐ Transfers
- ☐ Wheelchair Mobility
- ☐ Fall Risk
- ☐ Range of Motion
- ☐ Parkinson's Wellness Program

Speech Therapy
- ☐ Dysphasia (speech)
- ☐ Dysphagia (swallowing)
- ☐ Impaired Cognition
- ☐ Other: _____

- ☐ **Occupational Therapy**
- ☐ **Registered Dietitian**
- ☐ **Medical Social Worker**

Labs
- ☐ CBC
- ☐ CMP
- ☐ BMP
- ☐ UA
- ☐ PT/INR
- ☐ Other

Other
- ☐ Wound Care
- ☐ Palliative Care Program
- ☐ Lymphedema Therapy

Comments: _____

PLEASE FAX PROGRESS NOTES, MEDICAL RECORDS TO (805) 543-2224

FACE-TO-FACE DATE: _____ DIAGNOSES: _____

HOMEBOUND STATUS: _____

CLEAR SUBMIT

faxdist@cchh08.com