UNIVITA REFERRAL FORM

PATIENT REFERRAL INFORMATION	
Patient's First Name:	Patient's Last Name:
Member#:	DOB:
Health Plan:	Insurance Type:
Primary Phone Number:	Secondary Phone Number:
Home Address:	City, State & Zip Code:
Service Address:	Service City, State & Zip Code:
Alternate Contact Name:	Primary Phone Number:
Relationship to Patient:	Secondary Phone Number:
Primary Diagnosis & Code:	Secondary Diagnosis & Code:
Date of Discharge:	Facility Name:
Diabetic? □ No □ Yes Type: □ IDDM □ PO □ Diet	HT: WT:
Allergies:	
Are services medically necessary for home health care? □ Yes □ No	
PCP -Name of MD:	Phone Number: Fax Number:
Following MD (if other than PCP):	Phone Number: Fax Number:
Referrals' name:	Referrals' contact number: Referral Fax Number:

NURSING ORDERS:

☐ Nurse Evaluation – Evaluate for home or wound care needs & treatment
Wound care treatment plan & Location: ____

____

☐ Physical Therapy Evaluation & Treatment

☐ HT Evaluation & Treatment - home infusion/ medication(All first doses need to be given at the facility or PCP office)
Administration -Medication, dosage, route & frequency/ duration: ____________________________

____

☐ Other:____

FAX REFERRAL TO: 888-914-2202

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PHARMACY ORDERS:		
Medications (including medication name, dose, route, frequency, and duration):		
Lab Orders (as appropriate):		
IV Access:	Number of Lumens:	

DME ORDERS:		
HCPC Code	Description	Length of Need

NOTE: For Oxygen Orders, please provide:	
Liter Flow per Minute	
Route: Nasal Cannula, simple mask or other	
Date of last patient encounter: (MM/ DD/ YYYY)	
Hours of use: continuous, with exertion, hours of sleep, bleed into CPAP/BiPAP or other	
Delivery Device: concentrator, portable cylinders, conserving device, liquid Helios portable, or other	
Date of saturation test: (MM/ DD/ YYYY)	
Oxygen Saturation or PO2 results:	%

*******Attach all history & physical, discharge plans, any surgical reports, treatment and medication list******

SECTION C Physician Attestation and Signature/Date

I certify that I am the treating physician identified in this form. I have received the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ____ DATE _____/_____/_____

PHYSICIAN'S NAME (Please print):____

Signature and Date Stamps Are Not Acceptable

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