The Mindbridge Care, LLC

REFERRAL FORM

Skilled and Non-Skilled Home Care Services

Phone: (513) 299-8112 | **Address:** 8200 Beckett Park Dr, Suite 112, West Chester, Ohio 45069

1) REFERRAL INFORMATION

Date of Referral: _____ Time: _____ Start of Care Requested: _____

Urgency: ☐ Routine ☐ Urgent ☐ Same Day

Referred By / Facility: _____

Referral Contact Person: _____

Phone: _____ Fax: _____ Secure Email: _____

2) CLIENT / PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Primary Language: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Current Location: ☐ Home ☐ Hospital ☐ SNF ☐ Rehab ☐ Assisted Living ☐ Other: _____

Expected Discharge Date (if applicable): _____

3) INSURANCE / PAYMENT INFORMATION

☐ Medicare
☐ Medicaid
☐ Managed Medicaid / MCO: _____
☐ Commercial Insurance: _____
☐ Private Pay
☐ Long-Term Care Insurance: _____
☐ Other: _____

Policy / Member ID: _____

4) REFERRING PROVIDER / PHYSICIAN INFORMATION

Referring Provider Name: _____

Practice / Facility: _____

NPI: _____

Phone: _____ Fax: _____

PCP / Attending Physician: _____

5) SERVICES REQUESTED

A. Skilled Services

☐ Skilled Nursing
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Medical Social Work
☐ Home Health Aide
☐ Wound Care
☐ Medication Management
☐ Disease Management
☐ Post-Hospital Care

B. Non-Skilled Services

☐ Personal Care
☐ Bathing / Dressing / Grooming
☐ Meal Preparation
☐ Light Housekeeping
☐ Companion Care
☐ Respite Care
☐ Errands / Transportation Support
☐ Safety Supervision

The Mindbridge Care

REFERRAL FORM – CLINICAL INFORMATION & AUTHORIZATION

Skilled and Non-Skilled Home Care Services

6) CLINICAL INFORMATION

Primary Diagnosis / Reason for Referral: _____

_____

Secondary Diagnoses / Pertinent Medical History: _____

_____

Allergies: _____ Height: _____ Weight: _____ Oxygen: ☐ Yes ☐ No Liter Flow: _____

Infection / Isolation Precautions: ☐ Yes ☐ No If yes: _____

Fall Risk: ☐ Yes ☐ No

Cognitive Concerns: ☐ None ☐ Memory Loss ☐ Dementia ☐ Confusion

Wounds / Skin Issues: ☐ Yes ☐ No If yes: _____

Mobility / Transfer Needs: ☐ Independent ☐ Standby Assist ☐ One-Person Assist ☐ Two-Person Assist ☐ Wheelchair

Homebound / Leaving home requires considerable effort (if applicable): ☐ Yes ☐ No ☐ N/A

Brief Clinical Notes / Special Instructions: _____

_____

_____

_____

7) MEDICATION / EQUIPMENT / SAFETY

A. Medication Support Needed: ☐ Medication Reminder ☐ Medication Setup ☐ Medication Management ☐ Insulin ☐ Other: _____

B. DME / Equipment in Home: ☐ Walker ☐ Cane ☐ Wheelchair ☐ Hospital Bed ☐ Commode ☐ Shower ☐ Oxygen ☐ Other: _____

C. Safety / Support Needs: ☐ Fall Prevention ☐ ADL Assistance ☐ Bathing Assistance ☐ Meal Preparation ☐ Respite ☐ Companion Support ☐ Transportation Support ☐ Safety Supervision

8) DOCUMENTS ATTACHED

☐ Face Sheet / Demographics ☐ Insurance Cards ☐ Medication List ☐ History & Physical / Progress Note

☐ Hospital / Rehab Discharge Summary ☐ Physician Order / Referral Order ☐ Face-to-Face Documentation (if applicable)

☐ Wound / Treatment Orders ☐ Most Recent Labs ☐ Advance Directives (if available) ☐ Other: _____

Supporting clinical records, physician or qualified provider orders, and additional documentation may be required for skilled home health services, payer authorization, and start of care review.

9) AUTHORIZATION / SUBMISSION

By submitting this referral, the referring source confirms that the information provided is accurate to the best of their knowledge and may be shared with The Mindbridge Care, LLC for intake, eligibility review, care coordination, and service planning.

Referring Contact Signature: _____ Printed Name: _____ Date: _____

Best Call-Back Number: _____ Preferred Method of Follow-Up: ☐ Phone ☐ Fax ☐ Secure Email

10) AGENCY USE ONLY

Referral Received By: _____ Date / Time Received: _____

Services Accepted: ☐ Yes ☐ No ☐ Pending Start of Care Date: _____

Additional Follow-Up Needed: _____

Notes: _____

_____