In Home Care California
(IHCC)

19626 Ventura Blvd, Suite 228
Tarzana, CA 91356
Phone: 818-514-6424
Fax: 818-514-6461
homehealthcarecalifornia@gmail.com

Physician Referral Order

Patient Name:---------- DOB: ----------

Address: ----------

Home Phone # ---------- Mobile # ----------

email: ----------

Date Last Seen by Physician ----------

Insurance Provider: ---------- Member ID #:----------

Primary Diagnosis:----------

Additional Diagnosis:----------

Services Requested: (Check all that apply)

□ Skilled Nursing **□ Physical Therapy** **□ Occupational Therapy**
□ Speech Therapy **□ Medical Social Worker** **□ Wound Care**
□ Infusion Services

Equipment Required

□ DME ---------- □ Oxygen ----------

Intervention/Order:

□ Admit patient from ---------- through ----------

Frequency: ----------

□ Recertify Patient from a period of 60 days, from ---------- through ----------

Frequency: ----------

□ Discharge patient from home health services due to:

□ Patient/physician request

□ Patient moved to healthcare facility

□ All goals have been met

□ Patient moved from service area

Signature

Physician Name: ----------

Phone # ----------

Signature: ----------

Date:----------

Please attach and sign the following documents and fax them all to the fax number shown below.

1. **Most recent office visit notes (must be signed and dated by physician)**
2. **Medical History and Physical Examination Information**
3. **Lab results (if any)**

Fax documents to 818-514-6461