Cincinnati Children's
Home Care Services
513-636-HOME

PHYSICIAN'S ORDER FORM

Name_____
MR#_____DOB_____

All orders must be written in the metric system and include date, time, physician's signature and pager/phone number. Use ball point pen.

Weight _____KG Height _____CM Sex: ☐ F ☐ M

Allergies: ☐ None ☐ Drug/Contrast ☐ Food ☐ Product/Latex Specifics: _____

Address_____ City _____ State _____ Zip_____

Insurance provider_____

Home Health Care-Speech Therapy Referral Order Form

Home care is considered a short-term alternative to standard outpatient care. The goal of therapy is to improve medical status and/or functional abilities so that home care services are no longer needed and the child can resume more normal daily activities, including school.

☐ Start of care/evaluation will be within 14 days from the date patient referred to Home Care. Speech therapist to develop plan of care and visit frequency. A RN will complete a comprehensive assessment at start of care and every 60 days thereafter.
If Ohio Medicaid: I had a face to face encounter on _____ (date). **Addendum:** The clinical findings support Home Health eligibility because _____.

☐ Resumption of care within 48 hours of hospital discharge or _____ (date). Speech therapist to resume plan of care and visit frequency.

Evaluation and Treatment requested for (*please check all that apply*):

☐ Speech/Language

☐ Oral-Motor Feeding

☐ Other _____

Reason for Referral _____

Pertinent Medical/Development Information:

_____

_____

_____

_____

_____

Referral Source_____Phone #_____ Pager #_____

Attending Physician who will manage care of patient at home:_____

_____

Physician Signature/Credentials **PRINT NAME** **Pager** **Time/Date**

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HIC 03/11

Fax completed orders to Home Care Office (513) 636-7538 then place orders in CCHMC medical record.
Orders faxed on: (date) _____ (at time)_____ by (print name)_____

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