MEDSTAR Home Health

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MEDSTAR HOME HEALTH
Home Care Referral/Face to Face Encounter

Patient's Name _____ Date _____

Address_____

Patient's Ph # _____ Patient's DOB _____

Male ☐ Female ☐ Soc. Sec. # _____/____/_____ MC# _____/_____/_____

Referring Physician _____ Phone _____

Diagnosis: _____

_____

Facility/DC Home Health _____ SNF _____ Rehab _____ Hospital _____ Room # _____

Orders: _____

_____

Date of Face to Face Encounter: I certify that this patient is under my care and that I, a nurse practitioner or a physician's assistant working with me, had a Face to Face Encounter that meets the physician Face to Face Requirements with this patient on : (insert date visit occurred) _____/_____/_____.

I certify, by my signature below, that the following Home Health Services are medically necessary for this patient based on the clinical findings listed below: (Check Skilled Services Needed)
___ Skilled Nursing ___Physical Therapy ____ Occupational Therapy ____ Speech Therapy
___ Medical Social Worker ____ Home Health Aide ____ Private Pay Services

Clinical Findings: _____

_____

HOME BOUND STATUS: Further, I certify that my clinical findings support that this patient is homebound (i.e., absences from the home require considerable taxing effort, and are for medical reasons or religious services, and are infrequent or of short duration when for other reasons) due to: _____

_____

Physician Signature _____ Printed Name _____
Date Signed _____/_____/_____