Physician Orders for Home Health Services

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Patient Name: ______________________ Birthdate: ______________

☐ **Verbal Order** Read back and verified with Dr: ______________ Date: ________

Received by: ______________________

☐ **New Order** Request Date: ____________

Orders for Home Health

☐ Skilled Nursing for: ______________ ☐ Physical Therapy Evaluation for: ______________

☐ Occupational Therapy Evaluation for: ______________ ☐ MSW for: ______________

☐ Speech Therapy Evaluation for: ______________ ☐ CHHA for: ______________

☐ Additional Orders: ______________________

***Note: Would you please also fax if any of the following documents are available:**

☐ Patient Face Sheet/patient demographics info ☐ Insurance Info ☐ Most recent medication profile ☐ H&P

☐ Progress notes ☐ Discharge summary ☐ Recent labs

I certify that this patient is confined to his/her home and needs intermitted skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care and I have authorized the services on this plan of care and will periodically review the plan.

Physician Certification of Face-to-Face Encounter Addendum

The Affordable Care Act mandates that patients referred to Medicare Reimbursed Home Health Services must have a face-to-face encounter with the physician or non-physician practitioner. This encounter must occur within 90 days prior to the state of home health services or within 30 days of the start of care. Documentation of the physician is required and it must include all sections to be filled. Otherwise, we cannot bill for Home Health Services.

1. **PATIENT NAME:** ______________________ **DATE patient seen for medical condition:** __________
2. **MEDICAL CONDITION** which is the primary reason for Home Health referral:

   ____

3. **CLINICAL FINDINGS** that support the reason for Home Health Services, skilled nursing and/or therapy care:

   ____

(Example: Physical Therapy in needed to restore patient's ability to ambulate safely and independently following TKR surgery. RN Services are needed to assess response to and educate patient/caregivers in changes to medication regimen for management of CHF and atrial fibrillation. Patient is currently homebound following TKR surgery and is walker-dependent with painful ambulation.)

4. **HOMEBOUND * STATUS** justification based on medical condition or clinical findings:

☐ Dyspnea with minimal exertion

☐ Weak/Poor Balance / At Risk for Falls

☐ Gait instability

☐ Other: ______________________

☐ Weight bearing restrictions

☐ Requires supervision due to cognitive impairment

☐ Requires physical assistance to safety leave home

***Definition of homebound:** Absences from the home require considerable and taxing effort and are for medical reasons or religious services, or are infrequent or of short durations when f other reasons.

5. If this physician completing this form is not the patient's Primary Care Physician, the signing physician certifies that he/she is endorsing the patient to: ______________________ , patient's primary physician.
6.

PHYSICIAN SIGNATURE	PRINTED OR STAMPED NAME	DATE SIGNED

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