Fax: (650) 826-3374
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Physician Order / Face to Face Encounter for Home Health Services

Patient Name: (Last)________________(First)________________(M)________ **Gender:** _____

Phone (Home): ________________ (Cell): ________________ **DOB:** ____________

Homebound Status: My clinical findings from this encounter support the patient is homebound due to: (please check all that apply)

☐ Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation, or need assistance of another person in order to leave their place of residence.

☐ Patient has a condition such that leaving his or her home is medically contraindicated.

☐ Patient has a normal inability to leave home due to *high fall risk / unsteady gait / chairbound / bedbound / Confusion / SOB / Pain.

☐ Leaving home requires a considerable and taxing effort for the patient.

Face to Face Encounter Date: __________ **Primary Dx:** ________________________

Secondary Dx: ____________________________________

Additional Information/ Special Instruction: ________________________

Home Health Skilled Services Needed: (****Either RN or PT MUST BE Checked**)

☐ **RN**	☐ Vital Signs/O2 Sat Check	☐ Diabetic Care/Education (Glucometer use /Insulin/ Diet Compliance/ Foot Care)	☐ Wound Care/ Assessment/ Dressing Change / Wound VAC	☐ Lab/Blood draw/ Injection
	☐ Post- Stroke/CHF management/ Teaching	☐ Medication Assessment/ Teaching/ Management	☐ COPD Sx/ Oxygen/ SOB Management	☐ ESRD Sx Management
	☐ Pain Management	☐ Urinary Catheter Care	☐ Ostomy Care	☐ HTN Management
	☐ Home Safety and Fall Prevention	☐ Anticoagulation Management (PT/INR)	☐ Urinary / Bowl Incontinence	☐ Other:
☐ **PT**	☐ Mobility Training	☐ Home Exercise Program	☐ Gait Training	☐ Safety at Home
	☐ Fall Prevention	☐ DME Assessment/ Training	☐ ROM Exercise	☐ Caregiver Training
	☐ Balance Training	☐ Weight Bearing Limitations	☐ Strengthening Ex.	☐ Other:
☐ OT	☐ Safe ADLs Training	☐ Fine and Basic Motor Improvement Training	☐ Safety at Home	☐ DME Assessment/ Training
☐ ST	☐ Swallow Evaluation	☐ Speech Training/ Improvement	☐ Cognitive Training	☐ Other:
☐MSW	☐ Community Resources / Support	☐ Counseling for Advance Directive Planning	☐ Finding Alternative Living Arrangement	☐ Other:
☐HHA	(Certified Home Health Aide)	☐ Assist with personal care and ADL	☐ Other:	

Certifying Physician: ________________________ **NPI:**______________

Physician Signature: ________________________ **Date:**______________

Phone: ____________ **Fax:**_____________ **Form Preparer:**____________

Please Attach 1) Patient Demographics 2) Medication List 3) Progress Notes. Thank You!