HOME HEALTH REFERRAL/ORDERS

Patient Name :	**KC's Home Health Care** **20612 N Cave Creek Road, Ste F151** **Phoenix, AZ 85024**
Referring MD:	
MD to Follow :	
Diagnosis :	**INTAKE FAX: 602-626-7677**
Payer/Payer Information : Fax/Send Patient Demographic Sheet	□ **Patient Demographic Sheet** □ **H & P** □ **Signed Referral Orders for Home Health**

Skilled Nursing	Physical Therapy	Speech Therapy	Occupational Therapy
⌂ Observation & Assessment of chronic condition (condition):	Evaluate & Instruct for :	Evaluate & Instruct for :	Evaluate & Instruct for :
⌂ Medication Management ⌂ PT/INR Q____________________	⌂ Ambulation/Gait ⌂ Balance	⌂ Cognition	⌂ ADL's
⌂ Urinary Catheter Care: Catheter Type : Foley Supra Pubic Size:	⌂ Bed Mobility ⌂ Range of Motion ⌂ Strengthening	⌂ Hearing ⌂ Language Processing	⌂ Energy Conservations ⌂ Adaptive equipment
⌂ Enteral Feeding: Type: Amount: Frequency: ⌂ Intermittent ⌂ Continuous	⌂ Transfers ⌂ Weakness ⌂ Wheelchair Mobility	⌂ Voice Intelligibility ⌂ Other	⌂ Orthotics ⌂ Sensory Dysfunction
⌂ Wound Care : Location : Type:	Other :		⌂ Other
⌂ Telehealth			
⌂ IV Site Care :			

The remainder of the form must be completed by physician or physician support staff & signed by the physician

Documentation of Face-to-Face Encounter for Medicare Patient

Date of Face-to-Face Encounter : I certify that this patient is under my care and that I, or a nurse practitioner or physician assistant working with me had a face-to-face encounter on : (date of encounter) _______/________/_______________

Medical Condition : The encounter with the patient was in whole or in part for the following medical condition which is the primary reason for home health. (list condition) ____

Medical necessity : I certify that, based on my findings, the following home health services are medically necessary :
⌂ Intermittent Skilled Nursing ⌂ Physical Therapy ⌂ Speech Therapy ⌂ Occupational Therapy ⌂ Bath Aide

Clinical Findings : My clinical findings support the need for the above services **because** : __________________________________

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Homebound Status : I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taking effort and are for medical reasons or religious services and are infrequent and of short duration)
because : ____

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Physician Signature : ____ **Date :** ______________________________

Physician Printed Name : ____ **NPI # :** ______________________________