REFERRAL/FACE-TO-FACE ENCOUNTER/ADMISSION ORDER FORM
PATIENT INFORMATION

Name (last, first, middle):_____
Address: _____City:_____ State: _____ Zip: _____

DOB: / / Age: _____ Gender: _____ SSN: _____

Phone: ( ) Alternate: ( )

Medicare #: _____ Part A: _____ Part B: _____

Medicaid #: _____

Other: _____ ID: _____ Group: _____

Physician Name: _____ NPI: _____

Address: _____City:_____ State: _____ Zip: _____

Phone: ( ) Fax: ( )

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health services. The Face-to-Face visit findings must be related to the primary reason for home health admission.

Date of In-Person Visit: / / Diagnosis: _____

Services requested:

SN: ____ AIDE: _____ PT: _____ OT: _____ ST: _____ MSW: ____ WC: _____ PSYC: _____

My clinical findings support the patient's eligibility for home health services, including specific need for intermittent skilled nursing and/or therapy services:

I certify that my clinical findings, as evidenced in the face-to-face encounter, support that this patient is homebound (i.e., absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons) due to:

Physician Signature: _____ Date: _____