Documentation of Face to Face Encounter

Patient's Name: ______________________________
MR #: ________________

Medicare #: ________________ DOB: __________

MD Name: ____________________________
UPIN No. ____________________________
NPI:________________phone: ___________

Address: ______________________________
____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred):

____
Month Day Year

____
Primary Diagnosis

The encounter with the patient, diagnosis, was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition, check all that apply):

[ ] O.A. - Knees, Hips, Shoulders or Generalized	[ ] Fibromyalgia / polymyalgia
[ ] Rheumatoid Arthritis - Hands, Feet, Generalized	[ ] Sciatica w/o Radiation or w/Radiation
[ ] Cervicalgia / Cervical Spine Arthritis	[ ] Peripheral Neuropathy: Diabetic, Hypertensive or Both
[ ] Thoracic Strain / Muscle Spams	[ ] Uncontrolled Hypertension, Cardiovascular problems
[ ] Lumbago / Chronic Low Back Pain	[ ] Uncontrolled Diabetes: NIDDM or IDDM
[ ] Paresthesias of Extremities: Upper or Lower Ext	[ ] Loss of Balance and/or Vertigo
[ ] Herniated or Bulging Discs: C Spine or LS Spine	[ ] Unsteady Gait and/or Difficulty Walking
[ ] Respiratory Problems, CHF, Dysnea, SOB/OE	[ ] Integumentary Status problems, Wound and/or Ulcer
[ ] Other:	[ ] Other:

Other:

Sample. To use this form the MD must add it to him/her EHR.

I certify that, based on my findings, the following **services** are medically necessary home health services *(Check all that apply):*

☐ Nursing Services ☐ Home Health Aide ☐ Medical Social Worker
☐ Therapy Services: ☐ Physical ☐ Occupational ☐ Speech ☐ Respiratory

Services to be provided: ☐ Wound Care ☐ Therapy Eval/Services ☐ Diabetes Management ☐ B/P monitoring
☐ Other: ______________________________

Referred to the Home Health Agency:______________________________

My **clinical findings** support the need for the above services <u>because</u>:

[ ] Pain affects quality of life, ADL's and mobility	[ ] Treatment will improve patient's condition/disease
[ ] Treatment of uncontrolled illness may prevent complications and possible hospitalization	

Other: ______________________________

Further, I certify that my clinical findings support that this **patient is homebound** (ie absences from home require considerable and taxing effort and are for medical reasons or religious services <u>or</u> infrequently or of short duration when for other reasons) <u>because</u>: *(Mark all that apply)*

❑ Needs assist of 1-2 persons to leave residence
❑ Unable to safely leave home without assistance
Use of special transportation
❑ Needs assistance for all activities (ADL's)
❑ Medical restrictions
❑ Unsteady Gait
❑ Generalized Weakness
❑ Poor Vision and/or cognitive impairment
❑ Loss of memory and/or Psychiatric meds
❑ Bedbound (❑ Partial ❑ Complete)
❑ Dependent upon adaptive device(s)
Have a condition such that leaving his or her home is medically contraindicated
❑ Due to illness/disease requires assistance to ambulate
❑ Decreased Range of Motion
❑ Confusion/Forgetful
❑ Mobility/Ambulatory device(s) used: ❑ W/C ❑ Walker ❑ Cane ❑ Crutches Other: ______________
❑ Severe SOB
❑ Unable/Unsafe to go out of home alone/unattended
Exist a normal inability to leave home
❑ SOB upon exertion, or when ambulate more than ________ feet
❑ Gait disorders places patient at high fall risk
Leaving home must require a considerable and taxing effort: ______________________

❑ Other (specify): ______________________________

Physician Signature: ______________________________ Date of Signature: ______________________