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AMERICAN ADVANTAGE Home Care

PHYSICIAN FACE TO FACE ENCOUNTER

PATIENT:	PHYSICIAN:
MR#:	ORDER #:

DOB:	SOC DATE:	EPISODE:

☐ POC Certifying Physician ☐ Non-POC Certifying Physician

I certify that the above named patient is under my care and that I, or the nurse practitioner or physician's assistant working with me, had the required face-to-face encounter/telehealth visit satisfying the encounter requirements on the date below.

Face to Face Encounter/Telehealth Visit Date (MM/DD/YY): _____/ _____/ _____

The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was:

_____

_____

_____

_____

_____

I certify that, based on my findings, the following home health services are medically necessary for this patient and they will evaluate for (check all that apply): ☐ SN ☐ PT ☐ OT ☐ HHA ☐ MSW ☐ SLP ☐ Other _____

VITAL SIGNS PARAMETERS:

Systolic BP > _____ & < _____
Diastolic BP > _____ & < _____
Pulse > _____ & < _____
Respiration > _____ & < _____
Temp > _____ & < _____
FBS > _____ & < _____
RBS > _____ & < _____

☐ Or Agency Protocol

ORDERS:

☐ Vital Signs
☐ Blood Sugars
☐ Wound Care
☐ Foley Cath Care
☐ Colostomy Care
☐ Medication Response/Compliance
☐ Educate on Disease Processes
☐ Dietary Requirements
☐ Fluid Restrictions
☐ S/Sxs Complications
☐ Infection Control
☐ Oxygen Safety
☐ Labs: _____
☐ Home Exercise Program
☐ Therapeutic Exercise
☐ Manual Therapy Techniques
☐ Balance Training
☐ Gait Training
☐ Transfer Training
☐ Fall Prevention/Safety
☐ Ultrasound
☐ Electrical Stimulation
☐ TENS
☐ Prosthetic Training

OTHER ORDER(S): _____

I further certify that my clinical findings support that this patient is homebound because:

☐ Needs assistance for all activities
☐ Confusion/unable to safely leave home
☐ Needs the aid of supportive devices
☐ Residual weakness
☐ Severe SOB/SOB exertion
☐ Requires maximum assistance/taxing effort to leave home
☐ Unable to leave home unassisted

Any other clinical factors that affect homebound status: _____

_____

I certify that the above patient is under my care, requires the above home health service(s), and is confined to his/her home. These professional services are to be provided on an intermittent basis and I will review the established plan of care at least every two months. These services are related to the diagnosis stated above and/or conditions for which he/she received treatment.

Physician Printed Name: _____

Physician Signature: _____ **Date** _____

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You may include clinical documentation with this form. **Attach PDF(s)** **Submit (via email)**