Home Health Referral

Patient Name: _____ **DOB:** _____

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*** with this patient on: _____

I am ordering and certify that, based on my findings, the following services are medically necessary home health services (check all that apply):

- ☐ **Skilled Nursing** – for: _____
- ☐ **Physical Therapy** – for: _____
- ☐ **Occupational Therapy** – for: _____
- ☐ **Speech Language Pathology** – for: _____
- ☐ **MSW** (Requires primary service to order) – for: _____
- ☐ **Home Health Aide** – for: _____

Clarify Homebound Status. (Both criteria must be met)

<u>Criteria 1:</u> ***In order to leave their place of residence, the patient requires:***
(circle all that apply and specify below)

the aid of supportive devices *the use of special transportation* *assistance of another person*

_____

_____

<u>Criteria 2:</u> ***Describe why it is difficult or taxing for the patient to leave their home.***
Leaving home is a considerable and taxing effort due to:

_____

_____

_____

The encounter with the patient was in whole, or in part for the following medical conditions, which is the primary reason for home health care: (List primary diagnosis and all comorbidities- **ICD 10 codes**)

DX: _____ DX: _____ DX: _____ DX: _____

DX: _____ DX: _____ DX: _____ DX: _____

Physician Signature: _____ **Date:** _____