MISSION

HOME HEALTH

-REFERRAL AND FACE TO FACE ACCESS FORM-

PHYSICIAN ______________________________ **OFFICE CONTACT** ________________________

PHONE ______________________**FAX**__________________ **REFERRAL DATE**______________

PATIENT INFORMATION			
LAST NAME	FIRST NAME	SEX: M__ F__	TELEPHONE
DOB	SSN		DX
CAREGIVER NAME		CAREGIVER CONTACT NUMBER	

CHECK THE SERVICES NEEDED	SPECIFIC ORDERS
☐ SKILLED NURSING ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ SPEECH THERAPY ☐ WOUNDCARE ☐ MSW	______________________________ ______________________________ ______________________________

PLEASE INCLUDE THE FOLLOWING AND FAX TO: 850-972-0811

Demographic sheet, office visit notes, discharge notes, H&P, and any supporting information That supports the patient's need(s) for Home Healthcare services.

PHYSICIAN FACE TO FACE CMS REQUIREMENT

F2F Date: ____________________

(Physician face-to-face encounter requirements occurred on this date)

The patient is under my care (physician nurse practitioner, or physician assistant) and I have initiated the establishment of plan of care. I certify that this patient is confined to the home (homebound) and needs intermittent clinical home care. Based on my findings I certify that this patient is homebound and requires intermittent home health care. I (physician, nurse practitioner, or physician assistant) will continue to follow and review the home health plan of care.

Physician Signature ____________________________________**Date**______________

Print Name and Credentials____

NOTE: *Content of this form is based on current face to face encounter requirements. Physician may dictate this information to office staff or discharge planner for completion, or support staff may extract the narrative from the physician's own medical record of the encounter. Home Health agency employees are prohibited by statute from assisting in completion of this form.*