Westminster Canterbury AT HOME

REQUEST FOR HOME HEALTH SERVICES

PHONE: 757-496-1691 • FAX: 757-496-1771

Today's date: _____/_____/_____

PATIENT INFORMATION

Last Name	First Name	Middle	Sex: ❑ M or ❑ F
Street Address	City		Zip
Phone	DOB		SSN
Insurance: ❑ Medicare ❑ Other _____		Medicare / Policy #	
Emergency Contact Name		Emergency Contact Phone	

PHYSICIAN'S ORDER

- ❑ SKILLED NURSING - *Eval and Treat*
- ❑ PHYSICAL THERAPY - *Eval and Treat*
- ❑ OCCUPATIONAL THERAPY - *Eval and Treat*
- ❑ SPEECH THERAPY - *Eval and Treat*
- ❑ MEDICAL SOCIAL WORK
- ❑ HOME HEALTH AIDE

SPECIALTY PROGRAMS

- ❑ CHF
- ❑ CATHETER CARE
- ❑ POST-SURGICAL CARE
- ❑ WOUND CARE
- ❑ DIABETIC CARE
- ❑ OSTOMY CARE

Contact Name at Physician's Office	Phone	*Office Use Only:* *VO date* *by*

DOCUMENTATION OF FACE-TO-FACE ENCOUNTER

I, or a non-physician practitioner working with me, or an inpatient physician had a face-to-face encounter with this patient during which a medical condition was addressed which is the primary reason for home health care on (date): _____/_____/_____ (Month / Day / Year)

BRIEF NARRATIVE

Include an explanation of why the clinical findings of this encounter support that the patient is homebound and in need of either intermittent skilled nursing or therapy services

#1 Confined to the Home –
Describe why the patient is homebound. An individual shall be considered "confined to the home" (homebound) if <u>both #1-a and #1-b</u> are met:

<u># 1-a</u>. The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, **<u>OR</u>**
- Have a condition such that leaving his or her home is medically contraindicated

<u>#1-b</u> To be considered "Homebound," there must exist:

- A normal inability to leave home; **<u>AND</u>**

Leaving home must require a considerable and taxing effort.

#2 Need for Skilled Services
Describe what the RN, PT, or SLP and other services will be doing in the home. For example, "skilled nursing required to assess and manage new COPD regimen."

Referring Physician's Signature: _____ Date: _____

Referring Physician's Printed Name: _____

(The above signature covers both home health orders and required face to face encounter documentation)