Please fax completed/signed document to 877-756-3077
Please include all necessary documentation

St. Joseph Health Home Health

HOME HEALTH REFERRAL ✚ FACE-to-FACE ENCOUNTER ✚ PHYSICIAN ORDER

Patient Name:_____	Fax: 877-756-3077
Patient Phone:_____	Referral Date:_____
Patient Address/Facility:_____	DOB:_____
Contact Person:_____	Insurance Information:_____
	Contact Phone:_____

Face-to-Face Patient Visit Attestation

Required to support the need for Home Health Services

Please attach: ✚ Most recent office visit note, H&P or D/C Summary **that addresses the reason for home health**
✚ Face Sheet ✚ Med List

Medical Condition: At the encounter the patient exhibited the following clinical conditions which are related to the **reason for the home health services**_____
_____
_____

Clinical Findings that Support the Patient's Eligibility: Provide a summary of the clinical findings that support the patient's eligibility for the ordered home health services including a specific need for intermittent skilled nursing services and/or therapy services_____
_____
_____

Homebound: A patient is homebound if the absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons. A patient is homebound when he/she has functional, emotional, cognitive or medically ordered restrictions and requires assistance to leave the home.

What condition(s) caused the patient to be homebound?	**What assistive devices does patient need to use now?**	**Describe the effort needed for patient to leave home:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician Orders for Home Health Services

☐ RN for_____
☐ PT for _____
☐ ST for _____
Add-on Disciplines: ☐ OT ☐ HHA ☐ MSW
Additional Orders: _____
_____
_____

I certify that this patient is under my care and that I or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician's face-to-face encounter requirements with this patient on _____ (date of visit)

Physician Name:_____
Physician Phone:_____ PECOS/NPI_____
Physician Signature:_____ Date:_____