1001 Mt Hermon Rd
Salisbury, MD 21804

Getting *better* all the time.

Phone: 410-543-7550
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Home Health Face-To-Face Encounter **Referral Form**

Patient Name	Date of Birth	Medicare Number	Primary Care Physician	Date of Referral

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 that meets the physician face-to-face encounter requirements with this patient on:

______/______/______

Month Day Year

The encounter with the patient was in whole, or part, **for the following medical condition, which is the primary reason for home health care** (list medical condition / diagnoses):

____

____

I certify that, based on my findings, the following services are medically necessary home health services:

(Check all that apply)

- ☐ **Skilled Nursing**
  - ☐ **Instruct / Evaluate Disease Process**
  - ☐ **Instruct / Evaluate Medication Management**
  - ☐ **Labs:** ____________________
  - ☐ **Wound Care:** ____________________
- ☐ **Physical Therapy Eval and Treat**
- ☐ **Occupational Therapy Eval and Treat**
- ☐ **Speech Therapy Eval and Treat**
- ☐ **Medical Social Worker Eval and Treat**
- ☐ **Home Health Aide for personal care**
- ☐ **Other:** ____________________

My **clinical findings support the need for the above services** because:

____

____

Further, I certify that my **clinical findings support that this patient is homebound** (i.e. absences from home require considerable and taxing effort and are for medical reasons **or** religious services **or** are infrequent **or** of short duration for other reasons) because:

____

____

Physician Signature: ________________________ Date: __________

Printed Name and Address:

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