501 Health Services Drive
Seaford, DE 19973

Peninsula Home Care at Nanticoke
Established 1985
Getting *better* all the time.

Phone: 302-629-4914
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Home Health Face-To-Face Encounter **Referral Form**

Patient Name	DOB	Medicare Number	Medicaid 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**– not required for MEDICAID patients (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:

_____

_____

☐ Refer to Discharge Summary for additional information.

Physician Signature: _____ Date: _____

Printed Name and Address:

_____

Form: 000F2F Revised 11.13