MEDICARE FACE TO FACE ENCOUNTER FORM

Patient Name: _____ DOB: _____

Date of Home Health Encounter: _____ Physician Name: _____

Medical Diagnosis: _____

X Primary Reason for Home Health Referral:

- ☐ Catheter Management
- ☐ CHF
- ☐ Complications of Cancer
- ☐ COPD
- ☐ CVA
- ☐ Decline in ADL/IADL Function
- ☐ Mental Status Change
- ☐ Unstageable Disease Process
- ☐ Diabetes
- ☐ Disease Process Education
- ☐ Infection
- ☐ Joint Pain
- ☐ Joint Replacement
- ☐ Medication Management
- ☐ Other: _____
- ☐ Multiple Sclerosis
- ☐ Recent Surgery
- ☐ Swallowing Dysfunction
- ☐ Syncope
- ☐ Parkinson's
- ☐ Wound Care

○ Cardiac ○ Endocrine/Renal ○ GI/GU ○ Pulmonary ○ Other: _____

X Homebound Qualifications:

Patient is unable to leave home safely for the following reasons:

- ☐ Patient requires considerable effort and the use of an assistive device
- ☐ Patient experiences taxing effort even during short distances from the home
- ☐ Patient requires the use of a wheelchair and the assistance of at least one other person
- ☐ Patient experiences significant shortness of breath with increased activity
- ☐ Patient currently experiences significant weakness requiring the assistance of others
- ☐ Patient currently experiences impaired mobility/limited ambulation due to:
  - ○ Arthritis/Pain ○ Dyspnea/Endurance ○ Fracture/Wound
  - ○ Paralysis/Weakness ○ Safety/Cognition ○ Other: _____
- ☐ Patient presents with Poor Balance/Unsteady Gait and requires assistance to ambulate
- ☐ Patient is high risk for falls/has a history of falls
- ☐ Patient requires assistance to transfer safely
- ☐ Patient is chair bound and requires assistance for all transfers
- ☐ Patient is bedbound and requires assistance for all transfers
- ☐ Patient requires supervision and assistance when leaving home due to cognitive deficits

X Services Recommended:

- ☐ Skilled Nursing: _____
- ☐ Physical Therapy: _____
- ☐ Occupational Therapy: _____
- ☐ Speech Therapy: _____
- ☐ Medical Social Work: _____
- ☐ Home Health Aide: _____

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.

_____ _____

Physician Signature Date