

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics/face sheet) and office visit note to: 308-224-2870

PATIENT	Patient Name: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
	SSN: _____	Patient's Ph. #: _____	
	Patient's Address: _____	City: _____	State: _____ Zip: _____
	Last Flu Vaccine Date: _____	Referral Date: _____	
	Alternate Contact Name: _____	Alternate Contact #: _____	
	Primary Care Provider: _____	Insurance Information: _____ <i>(or attach copy)</i>	

Office Contact Name: _____ Office Contact Ph. #: _____

Diagnosis/Medical Condition: *List the diagnosis/medical conditions that are the primary reason the patient requires home health services.*

HgbA1C Date: _____ HgbA1C Result: _____

Skilled Services/Interventions: *describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.*

<input type="checkbox"/> Skilled Nursing for: _____	<input type="checkbox"/> Occupational Therapy: _____
<input type="checkbox"/> Physical Therapy for: _____	<input type="checkbox"/> Social Work: _____
<input type="checkbox"/> Speech Therapy for: _____	<input type="checkbox"/> Home Health Aide: _____

Additional Orders: _____

CERTIFICATIONS FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a physician assistant (PA) / nurse practitioner (APRN) working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date: _____ / _____ / _____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health services.

Physician Signature: _____ **Date:** _____

Physician Name (Print): _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit

Clinical Findings:
Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.

Homebound Status:
Describe the clinical and/or physical findings and the functional limitations that result in the patient's normal inability to leave home



We look forward to serving you and your patients.
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NOTICE: The attached communication contains privileged and confidential information. If you are not the intended recipient, DO NOT read, copy, or disseminate this communication. Non-intended recipients are hereby placed on notice that any unauthorized disclosure, duplication, distribution, or taking of any action in reliance on the contents of these materials is expressly prohibited. If you have received this communication in error, please destroy all pages and contact the sender or the Brookestone Home Health & Hospice office at 308-995-4375.