Home Health Referral Form
& Face to Face Document

LifePath Home Health

(336) 532-0100 Main Office **(336) 532-0516 Referral Fax**

Patient Name: _____ **DOB:** _____
I (MD or DO) attest patient had a face to face encounter on date: _____ **by**: _____ (MD, DO, NP or PA)

For the following Diagnoses/Conditions: _____

Narrative to include clinical findings to support the patient's homebound status & needs skilled home care services:

_____

_____

Certification of Homebound Status

Criteria: Must Meet A, PLUS B &/or C

☐ **A. Normal inability to leave home exists *and* leaving home requires a considerable taxing effort.**

☐ **B. The patient is in need of supportive devices; use of special transportation; or assistance of another person in order to leave home due to [Check all that apply]:**

☐ **Limited ambulation** ☐ **Unsafe ambulation** ☐ **Falls risk** ☐ **Mental or Psychiatric condition**

☐ **Risk of elopement** ☐ **Pain that restricts mobility** ☐ **Shortness of breath**

☐ **Other:** _____

&/OR

☐ **C. Leaving home is medically contraindicated due to [Check all that apply]:**

☐ **Immunocompromised/High risk for infection** ☐ **Infected/Draining/Complicated wound** ☐ **Recent surgery**

☐ **Physician ordered restrictions:** _____

Requiring the following Skilled Services:

☐ **Nursing: Skilled Observation & Assessment:**
- ☐ Chronic Disease Management
- ☐ Medication Management
- ☐ Trach care, Catheter care, IV care
- ☐ Wound Care: _____
- ☐ Lab/blood draw orders: _____
- ☐ Teach/Administer: IV, TPN, injections

Infusion/TPN Company: _____
Infusion/TPN Orders: _____
- ☐ Other: _____

☐ **Physical Therapy Evaluate & Treat:**
- ☐ Fall Prevention
- ☐ Weakness/Balance
- ☐ Gait training
- ☐ Functional Maintenance Program
- ☐ Pain management
- ☐ Home Safety Assessment
- ☐ DME Recommendations
- ☐ Other: _____

☐ **Social Work Assessment & Interventions:**
- ☐ Safety/Risk/Abuse/Neglect concerns
- ☐ Social/Emotional factors
- ☐ Financial & Community Resources
- ☐ Caregiver issues
- ☐ Long Range Planning

☐ **Occupational Therapy Evaluate & Treat:**
- ☐ Energy Conservation Instruction
- ☐ ADL Re-training/Adaptive Equipment
- ☐ Functional Maintenance Program
- ☐ Home Safety Assessment
- ☐ UE injury/dysfunction

☐ **Home Health Aide:** Assistance with Bathing/Dressing

☐ **Speech Therapy Evaluate & Treat:**
- ☐ Swallowing Evaluation
- ☐ Communication

Care Programs:

☐ **Dementia Care:** Nursing: Observation & Assessment; Occupational Therapy: Evaluate & Treat; Social Work: Evaluate

Based on above findings, I certify that this patient is homebound and needs intermittent skilled nursing care &/or physical therapy services. The patient is under my care, and I have initiated the establishment of the plan of care. This patient will be followed by a physician who will periodically review the plan of care.

Physician Signature (MD or DO only): _____ **Date:** _____

Physician Name (Print): _____

Person making referral: _____

***Please Fax:**
- Demographics - Last Office Note - Insurance Card - History & Physical