Humboldt County
2127 Harrison Ave. #3
Eureka, CA 95501
707-443-9332

St.JosephHealth
Home Health

HOME HEALTH FACE-TO-FACE PHYSICIAN ENCOUNTER DOCUMENT

Patient Name:___________________________ **DOB:**_____/_____/_____ **Potential SOC:**_____/_____/_____

I certify that the above patient is under my care and that I, the physician or a nurse practitioner/physician's assistant working with me or a physician in the hospital who has reported to me, had a face-to face encounter that meets the physician face-to-face encounter requirements with this patient on:

►**1**. **Date of the encounter with patient:** ______/______/______

►**2**. The **Medical condition(s)/diagnoses** which indicate the primary reason for homecare is/are:

____

____

____

►**3**. **Services** requested for initial care**: Check or write in any that are needed initially.**

☐ Nursing ☐ Physical Therapy ☐ Speech Language Pathology

Other services also needed: ☐ Occupational Therapy ☐ Social Worker ☐ Home Health Aide

►**4**. My **clinical findings support** the need for the above services because: **(*Please provide a brief narrative on why this patient needs home health*)**

____

____

____

►**5**. This patient is **homebound** for the following reasons: *please note what* ***diagnoses/conditions*** *cause patient to be confined to home, include* ***use of which assistive devices and specify the effort*** *required to leave home.*

(Please Complete each box)

A. What condition(s) caused the patient to be homebound?	B. What assistive devices does patient need to use now?	C. Describe the effort needed for patient to leave home:
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or will need occupational therapy. This patient is under my care, and I have authorized the services on a Plan of Care and I, or the community physician Dr. ______________________________, will periodically review the Plan of Care.

Physician's Signature Required:_____________________________________Date of Signature: _____________

Print Physician's Name: ____

FAX completed form to: **(707) 443-8142** **Attention:** **Medical Records**

Your office staff may help with the completion of this form. Only the physician must sign and date.

Form Updated Jan 2015