Napa County
980 Trancas Street, Suite 9
Napa, CA 94558
707-257-4124

St. Joseph Health 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 <u>why</u> 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 <u>and</u> 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: <u>(707) 224-7087</u> Attention: <u>Medical Records</u>

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