# Home Health Orders & Face to Face Encounter Information

Renown Home Health

3935 S McCarran Blvd, Reno, NV 89502

**Patient Date of Birth:**

**Patient Name:**

Homebound requirements:

***Check at least one****:* □ Pt needs aid of supportive device (i.e. walker, crutches, wheelchair, cane)

□ Pt requires use of special transportation

□ Pt needs assistance of other person to leave the home

□ Pt has condition such that leaving the home is medically contraindicated

**AND** Pt can only leave home through taxing effort? □ YES □ NO

**AND** Pt shows overall inability to leave the home frequently and for extended periods of time? □ YES □ NO

**Clinical diagnoses requiring home health services** *(Please be specific)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based on my face-to-face findings, the above patient is in need of skilled care, and I am ordering the following home health services: *(Check ALL that apply to the above patient)*

**Check at least one:**Optional services:

□ Skilled Nursing – evaluation & treatment □ Occupational Therapy – evaluation & treat

□ Physical Therapy – evaluation & treatment □ Medical Social Work – consultation

□ Speech Therapy – evaluation & treatment □ Registered Dietician – consultation

□ Home Health Aid – personal care assistance

**Additional Orders:**

🗹 Educate on disease process □ Wound vac per protocol

🗹 Perform home safety evaluations □ Wound care per protocol

🗹 Medication education & management

🗹 Wound culture may be obtained if- not healing, increasing redness/swelling, purulent draining, increased pain

🗹 Urinalysis may be obtained if- Dysuria, frequency, new incontinence, hematuria

**Will the referring physician oversee the Plan of Care and future orders?** □ YES □ NO

If no, name physician for follow-up care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing below, I certify that I, or the NPP/PA working with me, had an encounter that meets the face-to-face requirements for home health care with this patient on the above date. The encounter was in whole, or in part, for the above medical condition(s), which is/are the primary clinical reason(s) for referral to home health care. This document, along with additional clinical summaries, will be incorporated into the patient’s medical record.*

**Date of Face-to-face encounter**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Please attach the MD progress note from this date\*\****

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*Physician Signature Date (if different from encounter date)*

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*Physician Printed Name*

**\*When completed and signed, please fax to 775-982-7567\***