PATIENT INFORMATION

Patient’s Full Name

Date of Birth ____________________________  (Please provide all demographic information.)

Primary Reason(s) for HomeHealth Referral:

Healthcare Provider who will oversee HomeHealth:

ORDERS

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Focus of Care</th>
</tr>
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<tbody>
<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Skilled Nursing</td>
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<tr>
<td>Speech Therapy</td>
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</table>

DIAGNOSIS / DIAGNOSES (Cannot use a symptom as a diagnosis)

ADDITIONAL INFORMATION / NOTES NEEDED (Please provide the following documents.)

- History and Physical
- Order for HomeHealth Care
- Current Medication List
- Most Recent Office Visit Note, including documentation to support the reason for HomeHealth
- Face to Face visit - can be part of office visit note
- Special Orders – for example: wound care

PLEASE COMPLETE FOR PATIENTS WITH MEDICARE

Homebound Statement: Patient is homebound due to (limitations/ restrictions):

I certify this Patient is under my care, and that I, or a Provider working with me, had a Face-to-Face encounter with this patient that meets the Provider Face-to-Face encounter requirements.

Provider Signature & Title

Date of Face-to-Face Encounter:

Signature of Person Completing Form: ___________________________  Date: ____________________