

Fast Fax Referral & Face to Face Encounter

Fax To:

ACHC - Attn: Intake Department

Fax: 661-864-1004

Ph: 661-395-5800

Referred From: _____

Dr. _____

Sent by: _____

Date: _____

Total # of pages: _____

Phone#: _____

Patient Name: _____ **DOB:** ____/____/____ **DX:** _____

Include: Face Sheet H&P Copies of Insurance Card(s) Other _____

The findings from this face to face encounter indicate the reason(s) this patient requires intermittent skilled nursing care and/or therapy skilled services.

Home Health Skilled Services:

- | | | |
|---|---|--|
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> IV Therapy | <input type="checkbox"/> Wound Specialty Nurse |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> G-Tube Feeding | <input type="checkbox"/> NPWT |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Foley Catheter Care |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Diabetic Care | <input type="checkbox"/> Home Health Aide |

This patient is confined to the home for the following reason(s):

- Unable to ambulate > _____ feet without rest periods
- SOB with exertion/activity requires frequent rest
- Requires assistance of device and/or aid of another to leave home: _____
- Medically restricted to home due to _____
- Leaving home requires a great and taxing effort due to _____
- Needs assistance with activities and/or ambulation
- Confusion/Cognitive limitations make it unsafe for patient to leave home
- IV Therapy contraindicated to be in the community
- Unable to leave home due to confirmed or suspected COVID19 diagnosis or a condition making them more susceptible to COVID19

MD Order & Instructions: _____

I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical, occupational therapy and/or speech therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on ____ / ____ / _____ by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

Physician Signature (This certification may only be signed by an MD/DO/DPM)

Date