Home Health Referral/Face-to-Face Encounter Form

Name of Home Health Agency Provider: Brain Spine Ortho Home Care, LLC (Fax 888-342-2302)

Patient Name:	Date of Birth:

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on (date visit occurred): And have attached ☐ Patient demographics sheet

☐ Last office visit notes

The encounter with the patient was in whole, in or part, for the following medical condition, which is the primary reason for home health care:

List additional medical conditions:

I certify that, based on my findings, the following Home Health services are medically necessary (check all that apply): ☐ Physical therapy ☐ Skilled nursing

My clinical findings support the need for the above services because (check all that apply):

- ☐ Difficulty with mobility
- ☐ Difficulty caring for oneself due to debility from pain or weakness
- ☐ Difficulty managing condition
- ☐ Poor understanding of post-operative precautions/incision care
- ☐ At risk for higher level of care
- ☐ Poor management of comorbidities

Further, I certify that my clinical findings support that this patient's condition will make leaving the home difficult due to considerable and taxing effort required, occurs infrequently, and (check all that apply):

- ☐ Patient is at risk for falls
- ☐ Limited mobility due to pain, weakness, or dyspnea
- ☐ Requires assistive devices
- ☐ Requires support of caregiver

Physician signature:	Date of signature:

Physician printed name: