FACE TO FACE ENCOUNTER FORM

Last Name: ____ MRN: _____________________

First Name: ____

PATIENT IS HOME BOUND DUE TO:

☐ Patient requires special assistance when leaving the home. For Example, requires medical transportation or requires assistance of more than one person.

☐ It requires considerable and taxing effort for the patient to leave the home. For example, extreme fatigue or increasing physical symptoms from effort of excursion.

☐ The patient is confined to the home due to illness or injury. For example, MD has ordered patient to remain at home due to infection, weight bearing status or immunosuppressive issues.

☐ Other: ____

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THE PATIENT REQUIRES:

☐ Intermittent Skilled Nursing Services ☐ Occupational Therapist

☐ Physical Therapy ☐ Medical Social Worker

☐ Speech Therapy ☐ Home Health Aide

THE PATIEN REQURES THESE SERVICES DUE TO:

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The physician that will be assuming primary care responsibilities will be:

MD Signature: ____ Date: ______________________________

Print MD Name: ____

DATE FACE TO FACE OCCURRED

THIS FORM IS NOT VALID WITHOUT THIS DATE

DATE______________________________________

DATE FACE TO FACE OCCURRED

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433 Airport Blvd., Suite #129, Burlingame. CA 94010 Tel: 1.408.666.4805 Fax: 1.415.707.2037
contact@AllegroHomeHealth.com