VNA Home Health
The Perfect Balance of Healing & Home

FACE TO FACE FORM
Complete form in entirety with MD signature and fax to:

(518) 489-2532

Patient Name:_____ **Patient DOB:**_____

Face to Face Encounter Date: _____

I. Orders for Qualifying Home Care Services Needed:

□ **Skilled Nursing for:**
- □ **wound care**
- □ **medication management**
- □ **treatments (specify below)**
- □ **other**_____

□ **Speech Therapy for:**
- □ **restorative speech/language services**
- □ **other**_____

□ **Physical Therapy for:**
- □ **plan/implement therapeutic exercises**
- □ **therapeutic treatments (specify below)**
- □ **strengthening/gait training**
- □ **evaluate for OT**
- □ **other**_____

Additional Services needed:
- □ **Occupational Therapy for**_____
- □ **Medical Social Work for**_____
- □ **Home Health Aide for**_____

II. Describe how the patient's clinical findings as seen during this encounter support the need for skilled home care services. Medical Condition and Clinical Findings: _____

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III. Please indicate physician's clinical findings which support patient's homebound status and explain why patient's medical condition results in an inability to leave the home: *(Include for example: medical/surgical restrictions, physical limitations, cognitive or behavioral conditions, sensory deficits, immunological indicators)*

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_____

I certify that I (or the Nurse Practitioner or Physician Assistant working with me) had a face to face encounter with this patient on the above date.

Physician Name (print):_____

Physician Signature:_____ **Date**:_____
(Must be MD/DO signature)