Patient Name: ________________________  Patient DOB: ________________
Date: __________________

I. Orders for Qualifying Home Care Services Needed:

☐ Skilled Nursing for:
  ☐ wound care
  ☐ medication management
  ☐ treatments (specify below)
  ☐ other __________________________

☐ Physical Therapy for:
  ☐ plan/implement therapeutic exercises
  ☐ therapeutic treatments (specify below)
  ☐ strengthening/gait training
  ☐ evaluate for OT
  ☐ other __________________________

☐ Speech Therapy for:
  ☐ restorative speech/language services
  ☐ 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:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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)*

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

I certify that I (or the NP or PA working with me) had a face to face encounter with this patient on the above date. I certify that Dr. __________________________ has agreed to provide oversight in the community. I certify that I have written the plan of care that initiated this referral.

Date service requested to start: __________________________

Physician Name (print): ______________________________________

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