PROVIDENCE
Regional Medical Center
Everett

HOME SERVICES ORDERS/FACE TO FACE ENCOUNTER

1. Patient's Name:	2. Date of Birth:
3. ☐ Home Hospice 4. ☐ Home Infusion 5. ☐ Resume all previous Home Health Services, OR ☐ HHRN ☐ HHMSW ☐ HHPT ☐ Bath Aide ☐ HHOT ☐ HHSLP Home Health Instructions/Other:	6. ☐ Home Oxygen Flow Rate: select rate Liters/min ☐ Continuous ☐ Nocturnal ☐ With activity ☐ Other: _____

7. Sex: select	8. ICD-9-CM (if known)	9. Primary Diagnosis (Required):
10. Date of Face to Face Encounter:		11. Face to Face Encounter related to primary reason for Home Health: select one

12. **Required Documentation for Physician Narrative Statement:**
(Please refer to reverse side for definition of homebound status and skilled home health services)

a. **Clinical findings that support homebound status:**

b. **Clinical findings that support need for skilled home health services:**

c. **Specific skilled disciplines needed (RN, PT, OT, ST, HHA, MSW):**

13. **Print Physician's Name** _____ **Date (Required)** _____

Physician's Signature

_____ _____

Signature **Date (Required)**

For Office Use Only

1. Date provider received signed document _____
2. Planned start of care date _____
3. Staff Signature

Requires handwritten signature and handwritten date of that signature

This document is an addendum to the Home Health Certification of Care as required by the Centers for Medicare and Medicaid Services.