Physician Progress Note for Face to Face Encounter and Certification of Eligibility for Home Health Services

(Per Medicare regulations, this form cannot be filled out by the home health agency or anyone with a financial relationship to the home health agency.)

Patient Name:_____ **Date of F2F Encounter:**_____ **DOB:**_____

Information for Physician/NP/PA Conducting the Visit:

First and Last Name (please print): _____

Credentials: ☐ MD/DO/DPM ☐ NP/PA ☐ Other:_____

Medical diagnosis for which face to face encounter was conducted and for which home health care services were ordered:

_____

Patient Encounter Findings:

Subjective information:

_____

_____

_____

Objective information (physical exam findings, test results, progress/lack of progress, functional losses):

_____

_____

_____

Homebound Status:

(Does not apply to Medicaid patients)

Prior to this encounter, the patient was: ☐ Unable to safely leave home independently because of a medical condition

☐ Was able to leave home with minimal effort but there has been a change

The patient is now confined to the home because of the following medical conditions:

- ☐ Arthritis and weakness limits endurance and increases the risks for falls outside the home environment
- ☐ Unstable gait and muscle weakness due to _____
- ☐ Pain with activity which limits _____
- ☐ Shortness of breath develops after ambulating short distances and requires frequent rest periods
- ☐ Cognitive deficits which impairs orientation, judgment, or decision making
- ☐ Develops chest pain with exertion related to _____
- ☐ Recent surgery has activity restrictions: _____
- ☐ It is medically contraindicated for the patient to leave home because: _____
- ☐ Patient is bedbound because _____
- ☐ _____

Because of the conditions cited above, one or more of the following types of assistance to leave home is normally required:

- ☐ Assistance of another person is required for the patient to safely leave the home
- ☐ Supportive Devices are required to safely leave the home: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches
- ☐ Special Transportation is required to leave the home: ☐ Transport Van ☐ Ambulance

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Patient Name: _____ **Date of F2F Encounter:** _____

Plan:

This patient requires **skilled nursing** to:	Teach the patient/caregiver to: _____ _____ ☐ Administer the following: ☐ IV ☐ IM ☐ SQ medication(s) that the patient/caregiver cannot safely administer: _____ _____ ☐ Provide skilled assessment and teaching of oral medications because: ☐ Regimen is highly complex ☐ Patient is confused ☐ Patient has new medications ordered ☐ Patient is experiencing side effects ☐ Non-adherence to medication regimen is suspected ☐ other (explain): _____ _____ ☐ Administer infusion therapy that the patient/caregiver cannot safely administer ☐ Perform skilled: ☐ Wound Care ☐ Catheter Care ☐ Ostomy Care that the patient/caregiver cannot administer or there is no caregiver available to render the care. ☐ Instruct on Disease Management: _____ ☐ Assess and provide instruction on pain management ☐ Other: _____
This patient requires: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Language Pathology	☐ To assess and provide instruction on improving functional mobility at home ☐ To assess and provide gait training, strengthening, and/or balance exercises to restore the patient's ability to ambulate or transfer safely ☐ To teach patient and caregivers on non-pharmacologic pain reduction techniques and strategies ☐ To increase strength and endurance and restore range of motion post-surgery Surgical procedure: _____ ☐ To evaluate the need for assistive/adaptive devices or environmental modifications needed to address functional deficits and improve safety in performing ADLs ☐ To provide and instruct on home exercise program ☐ To assess and provide instruction on managing dysphagia safely ☐ To assess and provide instruction on managing aphasia and other language disorders ☐ Other (describe): _____ _____
This patient requires: ☐ MSW ☐ HHA	Describe why the patient needs these additional services: _____ _____

Signature of Physician, Podiatrist, Nurse Practitioner, or Physician Assistant Completing the Encounter Documentation:

_____

(Include Hand Written Date)

After signing this form, please place a copy in the patient's medical record and fax a copy to Advocate at Home at 630.368.5930.

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