OLD GLORY
HOME HEALTH CARE & ASSISTIVE CARE. EST 2023

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2108 W Laburnum Ave, Suite 230, Richmond, VA 23227
www.oldgloryhomehealth.com

HOME HEALTH REFERRAL | FACE-TO-FACE (F2F) CERTIFICATION FORM

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that a face-to-face encounter occurred related to the primary reason the patient requires home health services in accordance with CMS requirements.

Face-to-Face Encounter Date: _____ **Encounter Performed By:** _____

REFERRING PHYSICIAN / FACILITY INFORMATION

Physician Name: _____
NPI #:_____
Phone: _____
Fax: _____
Facility / Practice Name: _____
Follow-Up Physician (if different: _____
Phone: _____
Fax: _____

Skilled Nursing (SN) ☐ Evaluate & Treat

☐ Medication Management ☐ Disease Process Education ☐ Wound Care ☐ IV Admin / Teaching
☐ Lab Draws ☐ Medication Reconciliation
Diagnosis / Additional Orders:_____

Occupational Therapy (OT) ☐ Evaluate & Treat

☐ ADL Training ☐ Upper Extremity Strengthening
☐ Adaptive Equipment Training ☐ Cognitive
Diagnosis / Additional Orders:_____

Physical Therapy (PT) ☐ Evaluate & Treat

☐ Gait / Balance Training ☐ Fall Prevention ☐ Strengthening ☐ Mobility Training ☐ Transfer
Diagnosis / Additional Orders:_____

Speech Therapy (ST) ☐ Evaluate & Treat

☐ Dysphagia ☐ Communication Deficits ☐ Cognitive / Memory Deficits ☐ Voice Therapy
Diagnosis / Additional Orders:_____

Medical Social Worker ☐ Eval & Treat

Home Health Aide (HHA) ☐ Eval & Treat

PRIMARY DIAGNOSIS / CONDITIONS

☐ CHF ☐ COPD ☐ Diabetes ☐ CVA / Stroke ☐ Parkinsons ☐ Dementia / Alzheimer's ☐ Joint Replacement ☐ Cancer
☐ Pressure Ulcer / Wound ☐ Fracture ☐ Small Bowel Obstruction ☐ PNA ☐ Urinary Retention ☐ Osteoarthritis

HOMEBOUND STATUS

☐ Requires taxing effort to leave home
☐ Requires assistance of another person
☐ Requires assistive device
☐ Unable to ambulate safely
☐ Fall risk
☐ Cognitive impairment
☐ Requires special transportation

PHYSICIAN CERTIFICATION

Based on the above findings, I certify that this patient is confined to the home and requires intermittent skilled services as ordered above.

Physician Printed Name: _____

Physician Signature: _____

Date: _____

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