APEX
Home Health Care, Inc.
2607 W. 22nd Street, Suite #47 Oak Brook, IL 60523
Ph (630) 908-4830 Fx (630) 908-4837

HOME HEALTH REFERRAL / FACE-TO-FACE ENCOUNTER FORM

PATIENT INFORMATION

Last Name:	First Name:	Sex: □M□F
Address:	City:	State:
Zip Code:	Telephone#:	
Date of Birth:	Social Security#:	Language(s):

INSURANCE INFORMATION

Medicare#:	Medicaid#:	Commercial Insurance:
Subscriber#:	Policy#:	Group#:

I certify that this patient is under my care and that, I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: _____

The encounter with the patient was in whole, or part, for the following medical condition, which is the primary reason for home health care:

□ Primary / Revision total hip replacement-DOSx: _____
□ Primary / Revision total / UNI knee replacement-DOSx: _____
□ Post-Laminectomy / Spinal Fusion; Level (s) ___-DOSx: _____
□ OA Knee / Hip / Shoulder R / L / B/L
□ Rotator Cuff / Frozen Shoulder R / L
□ Other: _____

I certify that, based on my findings, the following services are medically necessary home health services (check all that apply):

□Skilled/Wound Care Nurse/freq: _____ □Physical Therapy/freq: _____ □Occupational Therapy/freq: _____

My clinical findings support the need for the above services because of the patient's need for:

□ Vital signs monitoring
□ Wound/incision monitoring/treatment: _____
□ Pain assessment and Instruction (s) related to pain management; New pain meds: _____
□ PT/INR monitoring and assessment for signs and symptoms of bleeding (patient on Coumadin VTE prophylaxis)
□ Evaluation of environment for safety (patient is fall-risk)
□ Gait training and instruction in the use of assistive device(s): _____
□ Instruction and monitoring of home therapeutic exercise program
□ Other: _____

Further, I certify that my clinical findings support that this patient is homebound (i.e., absences from home require considerable and taxing effort and are for medical or religious services or infrequently or of short duration when for other reasons) because:

□ Narcotic usage every 4-6 hours or other frequency: _____
□ Inability to safely ambulate a minimum of 100 feet with/without an assistive device
□ Illness of injury which restricts the ability to leave home except with an assistive device, special transportation or assistance from another person (s)
□ Fatigue due to anemia
□ Increased risk for infection and/or bleeding
□ Other: _____

Physician Signature: _____ Date of signature: _____