# VISITING NURSE SERVICE & HOSPICE OF SUFFOLK, INC.

Phone (631) 261-7200 - Fax (631) 912-1114

## CERTIFIED HOME HEALTH CARE REFERRAL (CHHA)

### PHYSICIAN SIGNING HOME CARE ORDERS

| PHYSICIAN NAME | Date |
|---|---|
| ADDRESS | |
| CITY STATE ZIP | |
| TELEPHONE # ( ) | FAX ( ) |
| NPI # | LICENSE # |
| OFFICE CONTACT | TELEPHONE # |

### PATIENT INFORMATION

| LAST NAME | FIRST NAME |
|---|---|
| Sex ☐ Male ☐ Female | TELEPHONE #1 TELEPHONE #2 |
| SERVICE ADDRESS | APT/BLDG# |
| CITY STATE ZIP | |
| DATE OF BIRTH | SOCIAL SECURITY |
| LANGUAGE SPOKEN BY PATIENT | |
| MENTAL HEALTH STATUS: ☐Oriented ☐Forgetful ☐Confused | |
| LIVES WITH ☐Caregiver ☐Family ☐Alone | |
| EMERGENCY CONTACT/RELATIONSHIP | |
| CONTACT TELEPHONE # DAY EVENING | |

### INSURANCE INFORMATION

| MEDICARE # | MEDICAID # |
|---|---|
| COMMERCIAL INSURANCE CARRIER | |
| POLICY # | |
| WC Y ☐ N ☐ | NF Y ☐ N ☐ |
| POLICY # | |

### PRIMARY REASON FOR HOME CARE

**Home Care Diagnosis**

1. _____
2. _____
3. _____

***Mandatory attach the following:**

1. Last office note
2. Current list of meds
3. History & physical
4. Face to Face

Is the patient homebound? ☐Yes ☐No

**Skilled Services**

☐RN ☐PT ☐OT ☐ST ☐MSW
☐Palliative Care Program
☐HHA *with RN & PT only*

**Skilled Nursing**

☐**Telemonitor: BP, P, O2 Sat, QD weight**
- ☐Teach CHF management self care
- ☐Teach COPD management self care
- ☐Teach HTN management self care

☐Diabetic Management self care
☐Teach Medication/Diet changes
☐Wound care ***attach written order/rx***
☐Ostomy care and teaching
☐Urinary catheter: care & teaching
Size _____Fr Size balloon _____ cc
Amount to install in balloon _____cc
Date last changed _____

**Physical Therapy**

Gait/Ambulatory Status
☐assistive device ☐walker ☐cane
☐bed bound
☐safety
☐home exercise program

**Additional Information**:

_____

_____

_____

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# CERTIFICATION OF FACE TO FACE ENCOUNTER FOR HOME CARE SERVICES

➔ Patient Name: _____ DOB: _____

**I CERTIFY THAT A FACE-TO-FACE ENCOUNTER WAS PERFORMED ON THE ABOVE NAME PATIENT.**

➔ Encounter Date: ____/____/_____ By: _____

Who is a (check one) ☐Medicare Enrolled (or Medicare Opted-Out) Physician OR a
☐Non-Physician Practitioner

Patient will be followed in the community by: Dr._____

➔ This encounter with the patient was necessitated by the following diagnosis and symptom(s), which is the **PRIMARY REASON FOR HOME HEALTH CARE SERVICES**:

_____

_____

_____

**The following clinical findings support** that the **PATIENT IS ESSENTIALLY HOMEBOUND**
*(homebound means that there exists a normal inability to leave home and consequently, leaving home requires considerable and taxing effort)*
**AND** that the **PATIENT NEEDS INTERMITTENT SKILLED NURSING AND/OR PHYSICAL/ OCCUPATIONAL/SPEECH THERAPY:**

_____

_____

_____

➔ **Homebound because:**

_____

_____

_____

➔ ☐ **Skilled Nursing Care for** _____

_____

_____

☐ **Physical/Speech/Occupational Therapy for:** _____

_____

_____

➔ I certify that the above stated patient is homebound and that upon completion of the FTF encounter, has a need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician.

_____

**PHYSICIAN SIGNATURE** **PRINT NAME** **DATE**