DFW Area Tel: 214.987.2100 / 817.953.8586
EAST TEXAS Area Tel: 903.593.1737

Intake Fax:
844.979.1272

Date: _____

MD Name: _____

Address: _____

Tel: _____ **Fax:** _____

Contact Person: _____

Fax Included:
- ☐ Face- Sheet
- ☐ Demographics
- ☐ H & P
- ☐ Physician order
- ☐ DC Summary
- ☐ Rx List
- ☐ Face-to-face encounter
- ☐ Other: _____

Patient Information:

Name: _____ SSN#: _____ Gender: F☐ M☐

Tel: _____ Alternate #: _____ DOB: _____

Address: _____

Insurance Information:

☐ Medicare#: _____ ☐ Others: _____

My clinical findings support that this patient is homebound and meets the need for the below services because:

Detail explanation: _____

_____

_____

_____

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 (**Insert date that visit occurred**):_____ . I certify that, based on my findings, the above services are medically necessary home health services.

HOME HEALTH ORDER	SPECIALTY PROGRAM	
☐ Skilled Nursing	☐ Cardiovascular Care	☐ Orthopedic Care
☐ Physical Therapy	☐ CHF care(LVAD, IV Inotropes)	☐ Ostomy Care
☐ Occupational Therapy	☐ Diabetic care	☐ Post-Surgical Care
☐ Speech Therapy	☐ Infusion Therapy	☐ Respiratory (COPD, PNA, Vent)
☐ MSW	☐ Medication Management	☐ Strength/Balance Program
☐ Home Health Aide	☐ Neurological care (Stroke, MS)	☐ Transplant care
☐ Others: _____	☐ Oncology care	☐ Wound Care

Detailed Orders: _____

_____

_____

_____

Physician Signature: _____Date: _____