ALASKAN HOME HEALTH, INC. REFERRAL
FACE TO FACE VERIFICATION FORM
HOME HEALTH PHONE: 907-830-8548
HOME HEALTH FAX: 907-868-2958

PATIENT NAME: Last	Middle	First	DOB:

Patient Phone:	Sex:	Patients Physical Address:

Primary Diagnosis:	Primary Care Physician/NPI:

RECENT FACILITY ADMISSIONS (PAST 2 WEEKS)

Admit Date _____/_____/_____ **Anticipated Discharge Date** _____/_____/_____

☐ Hospital ☐ Long Term Acute Care ☐ SNF ☐ Inpt Rehab

Comfort Measures

☐ DNR/DNI ☐ Advanced Directive

☐ Comfort One Cert #_____

Patient's medical condition (as verified during this encounter) that supports homebound criteria and the need for the specified skilled services:

Skilled Nursing (SN)

- ☐ Evaluation/Treatment
- ☐ Wound Care (Please attach orders)
- ☐ Medication Management
- ☐ Skin Assessment
- ☐ Nutrition/Hydration
- ☐ Pain/Symptom Management
- ☐ Bowel/Bladder
- ☐ Diabetic Management
- ☐ Ostomy Care (Please attach instructions)
- ☐ Foley Catheter (Please attach instructions)
  - Size:
  - Date Placed:
- ☐ Blood Draw
  - Dates:
  - Results directed to:
  - Coag Check: ☐ Yes ☐ No
- ☐ Other:

Physical Therapy (PT)

- ☐ Evaluation/Treatment
- ☐ Home/Safety Evaluation
- ☐ Gait/Transfer Training
- ☐ Therapeutic Exercise
- ☐ Balance Training

History of Falls: ☐ Yes - #_____ ☐ No

Weightbearing Status: ☐ WBAT ☐ PWB ☐ TTWB ☐ FWB

Extremity: _____

- ☐ Other:

Speech Language Pathology (SLP)

- ☐ Evaluation/Treatment
- ☐ Cognitive Assessment
- ☐ Speech Assessment
- ☐ Swallow Assessment
- ☐ Other:

Occupational Therapy (OT)

- ☐ Evaluation/Treatment
- ☐ ADL Training
- ☐ Therapeutic Exercise
- ☐ Cognitive Evaluation
- ☐ Wheelchair Assessment
- ☐ Adaptive Equipment Needs
- ☐ Other:

Home Health Aide (HHA)

- ☐ Establish Plan of Care

Social Work (MSW)

- ☐ Financial Issues
- ☐ Transportation Assistance
- ☐ Depression Management
- ☐ Other:

I certify that this patient is under my care and that I, or a nurse practitioner (NP) or physician's assistant (PA) working with me, had a face-to-face encounter (a visit within 90 days prior to or no later than 30 days following this certification).

Face-to-Face Encounter Date: _____/_____/_____ Start of Care Date: _____/_____/_____

I certify, that based on my findings, this patient is homebound and skilled nursing and/or therapy services are medically necessary:

Physician Printed Name: _____ NPI: _____

Physican Signature: _____ Date of Signature: _____/_____/_____

Physican Phone Number: _____

Physican Fax Number: _____

Please attach: Face Sheet/Demographics, Insurance Information, H & P, Discharge Summary (if applicable), Updated Medication List, Any Wound Care or other orders and PCP (Name, Address, Phone #)