PATIENT REFERRAL FORM
PHYSICIAN CERTIFICATION OF FACE TO FACE ENCOUNTER

Patient

Last Name: ______________________ First Name: ______________________

DOB: ______________________ Medicare #: ______________________

Face-to-Face Visit Attestation

I certify that this patient is under my care and that I, or a nurse practitioner/clinical nurse specialist/ certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with this patient on:

Date of Last Face to Face Encounter: ______________________

Medical Condition: The encounter with the patient was directly related to the following medical condition, which is the primary reason for home health care:

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Clinical Findings Supporting Skilled Service: Provide a summary of clinical findings that support the specific need for intermittent skilled nursing and/or therapy services.

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☐ Skilled Nurse for ______________________

☐ Physical Therapy for ______________________

☐ Occupational Therapy for ______________________

☐ Speech Therapy for ______________________

Clinical Findings Supporting Patient is Confined to the Home:

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I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy.

Physician Name: ______________________ Office Contact: ______________________

Physician Signature: ______________________ Date: ______________________

Telephone: ______________________ Fax: ______________________

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