HAVEN HOME HEALTH, LLC

*Experience the difference in patient care!*

# PATIENT REFERRAL FORM

## PHYSICIAN CERTIFICATION OF FACE TO FACE ENCOUNTER

**Patient**

**Last Name:** ________________________ **First Name:** ____________________

**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**:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

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

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Skilled Nurse for ______________________________________________________________

Physical Therapy for ___________________________________________________________

Occupational Therapy for _______________________________________________________

Speech Therapy for _____________________________________________________________

**Clinical Findings Supporting Patient is Confined to the Home:**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**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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