

Face-to-Face Progress Note and Home Health Orders

IMPORTANT: For orders to be carried out, you must check the box next to the **service** needed (services identified by bold letters). Initial certification and orders must be signed and dated by attending physicians. The Home Health Orders portion of the form for resumption of care or an update to the initial certification can be completed by any provider.

Patient name: _____	Patient DOB: ____/____/____ Month Day Year
Anticipated date of discharge: (applies only to hospital or facility) _____	
Attending physician expected to follow patient: (first and last name) _____	
Attending physician phone number: _____	

Face-to-Face Encounter occurred on: ____/____/____ (should be within 90 days of start of care)
Month Day Year

Is this visit related to the primary reason the patient requires home health services? Yes No

Clinical Findings

Patient's medical condition or diagnosis of _____ results in:

Check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Instability | <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Immune-compromised |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Non-weight or partial weight bearing | <input type="checkbox"/> Pain with ambulation |
| <input type="checkbox"/> Generalized weakness and fatigue | <input type="checkbox"/> Wound infection or non-healing wound | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Other: _____ | | |

Homebound Status

Due to the above stated illness, injury or surgical procedure (medical condition or diagnosis) and associated clinical findings, the patient is homebound because of his/her inability to leave home except with aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated.

REQUIRED: Must complete both sections of this table to meet homebound eligibility criteria.

Patient requires the following assistance to leave the home: (Check all that apply)

- Cane Walker Wheelchair Aid of another person Medically contraindicated

AND (required)

Patient cannot leave the home or requires assistance to leave the home because: (Check all that apply)

- High fall risk due to gait instability
 Muscle weakness
 Cognitive deficits impact judgment, impair ability to safely navigate and prevent decision making for safety
 Shortness of breath/distress after ambulating more than 10 feet results in high risk for falling
 Recent lower/upper extremity surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation
 Patient is bedbound due to: _____
 Other: _____

Home Healthcare Orders

Skilled Nursing [Check all that apply]

- Medication management (specify): _____
- Anticoagulation
- New cardiovascular medications
- Diabetes Mellitus Assessment/Teaching
- Cardiovascular Cardiopulmonary (CV/CP) Assessment
- Wound Care: (specify wound care and treatment) _____

Other: _____

Patient name: _____

Infusion Therapy [Check all that apply]

IV medications [ie: antibiotics, chemotherapy, etc]

Name and dosage:		
Frequency and duration		
Type of line:	Location:	Date of insertion:

TPN [requires a completed TPN Order Form indicating type of formula]

Start Date:	Type of Line:
Location:	Date of Insertion:

Cathflo® (Alteplase) 2mg for each occluded lumen, per manufacturer instruction, as needed, while patient is on IV therapy.

Tube Feeding [requires a completed Tube Feeding Order Form indicating type of formula]

Start Date:	Date of Insertion:
Type of Tube <input type="checkbox"/> PEG <input type="checkbox"/> PEJ <input type="checkbox"/> Other (specify)	

Labs [Check all that apply]

- Venipuncture (specify): _____
- PT/INR: _____ times/week. May use PT/INR meter.
 - Planned date for first INR: _____
 - Goal INR Range: _____
- Other Labs – specify type and frequency: _____

Send results to: _____ Phone: _____ Fax: _____

Therapy Orders [Check all that apply]

- Physical Therapy** **PT assess for OT** **Occupational Therapy** **Speech Language Pathology**
(must have skilled nursing or PT ordered)

- Provide gait training, strengthening and/or balance exercises to restore the patient's ability to walk safely without pain.
- Increase strength and endurance and restore ROM s/p _____ surgery.
- Evaluate for assistive devices and/or environmental modifications needed to address ADL deficits to improve safety with transfers and ambulation.
- Teach the patient caregiver compensatory strategies for cognitive deficits.
- Teach patient caregiver compensatory environmental modifications for safety.
- Evaluate and treat dysphagia.
- Evaluate and treat aphagia.
- Provide maintenance therapy to prevent or slow a decline in condition.
- Other (describe): _____

Medical Social Worker [Must also have skilled nursing, physical therapy or speech therapy ordered]

Home Health Aide [Not PCA service; must also have skilled nursing, physical therapy or speech therapy ordered]

Signature: _____ NPI #: _____ Date: / / Time: _____

Print Name: _____ Pager/Phone: _____

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