SAMARITAN HOME HEALTH, INC.
165 Coleman Ave.
Watertown NY 13601
Phone: (315) 782-0415 Fax: (315) 786-0417

Physician – Patient
<u>Face to Face Encounter</u>

Patient Name:____DOB:____________________

I certify that is 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: (Date)____.

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):
____
____
____

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):
___________ Nursing
___________ Physical Therapy
___________ Speech Language Pathology

My clinical findings support the need for the above services <u>because</u>:

____
____
____
____

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services <u>or</u> infrequently or of short duration when for other reasons) <u>because</u>:

____
____
____
____

_____________________________________ ______________ _______________
Physician Signature Date Time

____
Physician Printed Name

Complete, Sign and Return to Samaritan Home Health

Samaritan Home Health, Inc.
Home Care Referral and Treatment Plan

Patient: ______________________ Date of Birth: ______________
Address: ____
Phone Number: ______________________
Insurance: ______________________________ Policy #: ____________

Referred for: ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy
☐ HHA ☐ Lab Work ☐ Speech Therapy

Following Documents needed: ☐ History & Physical ☐ Current Medication List
☐ Face to face Encounter (Medicare only)
☐ Scripts for orders ☐ Demographic Sheet

Diet: ______________________ Allergies: ______________________
Any restrictions: ____
Wound care (dressing changes, treatments, cleansing agents, frequency) ______________
____
____

Additional Instructions:

Diabetic ☐ Yes ☐ No
Fall Risk ☐ Yes ☐ No
Fluid Restriction ☐ Yes ☐ No
Pressure ulcers present ☐ Yes ☐ No If yes location and stage: ______________

Needs Asst. with ambulation ☐ Yes ☐ No
Lives Alone ☐ Yes ☐ No

____
____

Educational Needs

☐ Pressure ulcer
☐ Pain Management
☐ Coumadin
☐ Diet
☐ Lovenox
☐ Ostomy Mangement
☐ Activity
☐ Catheter/drain Management
☐ Diabetes Management
☐ CHF
☐ Precautions

Next MD Appt (Doctor Name, phone number, date and time) ______________________

______________________________ ______________________
MD Signature Date