Golden Valley Medical Clinics

Clinton
1602 N Second
Clinton MO 64735
Tel: (660) 885-8171
Fax: (660) 890-8478

Osceola
286 Chestnut
Osceola, MO 64776
Tel: (417) 646-2231
Fax: (417) 646-2338

Warsaw
1771 Commercial
Warsaw MO 65355
Tel: (660) 438-5193
Fax: (660) 438-9427

Windsor
100 South Tebo
Windsor MO 65360
Tel: (660) 647-2147
Fax: (660) 647-2160

HOME HEALTH REFERRAL/FACE-TO-FACE ENCOUNTER

Last Name: EMRTest First: Jane MI: B

Address: 1234 Sunshine Dr, P O Box 556, Clinton, MO 64735 Phone: (417) 644-2513

Staying (if different than above): _____

Diagnosis: TESTING #2 Visit date: 2/23/2014

(Reason for Home Health Referral)

Encounter Date and Reason

I certify that a face-to-face (FTF) encounter was performed on this patient on 2/23/2014 (date) by me as the certifying physician, or a nonphysician practitioner working under my supervision, or an inpatient physician or nonphysician practitioner working under the supervision of an inpatient physician during an acute or post-acute stay, and that the findings from that encounter were communicated to me.

This FTF encounter was related to the primary reason the patient requires home health services:

Orders

PHYSICAL THERAPY
- ☐ evaluate - treat
- ☐ gait training
- ☐ knee protocol
- ☐ hip protocol
- ☐ pain control
- ☐ EGS - ultrasound
- ☐ prosthetics

AIDE
- ☐ personal care
- ☐ bath
- ☐ exercise - ambulation

SKILLED NURSING
- ☐ lab _____
- ☐ assessment
- ☐ wound _____
- ☐ IV _____
- ☐ PICC _____
- ☐ ostomy _____
- ☐ G-tube

OCCUPATIONAL THERAPY
- ☐ evaluate - treat
- ☐ ADL training
- ☐ adaptive equipment
- ☐ home safety evaluation

MEDICAL SOCIAL SERVICES
- ☐ assess social - emotional
- ☐ community resources
- ☐ counseling

SPEECH THERAPY
- ☐ evaluate
- ☐ treat
- ☐ dysphagia

Homebound Reason

I certify that home health services are medically necessary, including either intermittent skilled nursing and/or therapy, and this patient is homebound in that absences from the home require considerable and taxing effort, are infrequent or of short duration or are attributable to the need to receive home care.

Homebound reason options (select all that apply):

- ☐ Requires assist of 1-2 people to leave home due to _____
- ☐ Transfer ability compromised due to _____
- ☐ Ambulation distance limited by Dyspnea or pain.
- ☐ Medically contraindicated to leave the home due to _____
- ☐ Minimal weight bearing and restrictions on walking due to _____
- ☐ S/P surgery which has resulted in temporary limitation on ambulation.
- ☐ Other: _____

Printed certifying physician name and credentials: William Dailey, MD

Electronically Signed by: Johnny Ingham, IT Analyst 2/24/2015 8:59:00 AM