Home Health of Choice: SOUTH DAVIS HOME HEALTH

Certification of Home Health/Face to Face Documentation

Face to Face Encounter

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, has a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on (insert date of visit occurrence): ______________________________
Month Day Year

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 ☐ Occupational Therapy ☐ Speech Language Pathology

My clinical findings support the need for the above services **because**: _____________________________
____

Nursing:

- Disease management/education (i.e. HTN, CHF, DM, CVA, infection, pneumonia, cellulitis)
- Medication management/teaching (i.e. new medications, compliance issues)
- Administration of medication (i.e. B12 IM, IV Antibiotics): _________________________________
- Wound care: ____
- Urinary catheter care
- Other: ____

Physical Therapy:

- Evaluation and treatment (gait training, HEP, ROM)
- Balance evaluation/training (i.e. vestibular)
- Lymphedema treatment
- Other: ____

Other: ____
____

Physician signature: ____ Date: ________________

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