



Referral Form / Face-to-Face Encounter Form

Richmond – Phone: (804) 377-1188 • Fax: (804) 377-1189

Tidewater – Phone: (757) 391-4088 • Fax: (757) 321-8227

www.americanhomehealthcare.com

Patient: _____
Last First MI

Address: _____

City State Zip

Phone/Cell#: _____ DOB: _____ Social Security #: _____

Emergency Contact Name: _____ Phone/Cell#: _____

Insurance: _____
Name Policy #

My clinical findings support that this patient is homebound and meets the need for the below services

because: _____

Home Health Order		Specialty Program	
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Cardiac/CHF Care	<input type="checkbox"/> Ostomy Care	
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> COPD Care	<input type="checkbox"/> Strengthening/Balance Program	
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Diabetic Care	<input type="checkbox"/> Stroke Care	
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Wound Care	
<input type="checkbox"/> MSW	<input type="checkbox"/> Neurological Care		
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Orthopedic Care		
<input type="checkbox"/> Other _____			

Detailed Orders: _____

Referral Contact: _____
Print Name Phone

I certify that this 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 (Insert date that visit occurred): _____. I certify that, based on my findings, the above services are medically necessary home health services.

Physician Signature: _____ Date: _____

Physician Printed Name: _____