



AmeriCare
 Home Health Services, Inc.
 5020 Tamiami Trail N • Suite 202
 Naples, FL 34103
 Phone (239) 261-0313 • Fax (239) 261-0316

PATIENT REFERRAL FORM

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Social Security #: _____

Insurance Information: _____ Medicare #: _____

Diagnosis: _____

Nursing:

- ___ Skilled Observation/Assessment
- ___ Medication Management/Teaching
- ___ Home Health Aide **
- ___ Social Worker **

Therapy:

- ___ PT Evaluation/Treatment
- ___ ST Evaluation/Treatment
- ___ OT Evaluation/Treatment **

** not a Medicare qualifying skill

Specific Instructions/Orders: _____

CERTIFICATION OF FACE TO FACE ENCOUNTER FOR HOME CARE SERVICES

I certify that a * qualified face to face encounter occurred on _____ with the above mentioned patient for the following medical condition (s) _____

The following clinical findings support that the patient is homebound and that the patient needs intermittent skilled nursing, physical therapy and/or speech-language pathology: _____

Certifying Physician Signature

Certifying Physician Printed

Date

* The physician must document when the physician or allowed non-physician practitioner (NPP) saw the patient and documented how the patient's clinical condition as seen during that encounter supports the patient's homebound status in need for skilled services. The face-to-face encounter must occur within 90 days prior to the start of home health care, or within the 30 days after the start of care.