Jefferson County
PUBLIC HEALTH SERVICE

Public Health Facility, 531 Meade Street, Watertown, New York 13601

"SAMPLE" Documentation of Face to Face Encounter for Home Care

Patient Name and Identification (DOB and/or Medicare #):

Mary A. Brown *DOB 4/30/46* *MC# 123456789A*

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 full date that visit occurred) :

January *5* *2012*

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 (Diagnosis or Problem): SAMPLES:

1. New onset (COPD. CHF. Diabetes, etc)
2. Total Knee Replacement 12/31/11
3. Exacerbation of COPD, CHF, etc
4. Wound Care for a Non-Healing Wound
5. Declining Mental Status
6. Patient needs Medication Evaluation & Education

I certify that, based on my findings, the following home health services are medically necessary. Check all that apply:

X	Skilled Nurse		Speech/Language Pathology	
X	Physical Therapy			

The above services will provide the following care/treatments: (Required only when the physician completing the face to face encounter documentation is different that the physician completing the plan of care):

_____

_____

My clinical findings support the need for the above services because: SAMPLES:

1. *Patient requires skilled monitoring, education & treatment due to an exacerbation of (CHF, COPD, etc)*
2. *Patient has a new diagnosis of CVA & needs skilled monitoring, education & treatment*
3. *Patient needs monitoring & treatment for recovery from Total Knee Replacement on 12/31/11*

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable & taxing effort & are for medical reasons, religious services or infrequently or of short duration when for other reasons) because: (Must be a Short Narrative) SAMPLES:

1. *Patient experiences shortness of breath & fatigue severely limiting ambulation distance & ability to manage activities of daily living.*
2. *Patient has functional deficits 2° to a new diagnosis of stroke & requires assistive device to ambulate.*
3. *Cardiac instability & compromised ejection fraction contraindicates patient leaving home.*
4. *Mental status changes affects patient's judgment & prohibits pt's ability to safely leave the home*
5. *Patient had a TKR left and is walker dependent with painful ambulation.*

Physician Signature (PA or NP cannot sign)_____

Date of Signature: _____

Physician Printed Name: _____

Please fax completed form to 315-786-3751. Thank You.