Brazosport Regional
HOME HEALTH SERVICES

194 Abner Jackson Parkway
Lake Jackson, TX 77566
Phone: 979-299-3236 Fax: 979-299-6407
Toll Free: 1-800-840-3574

HOME HEALTH CARE ORDER

REFERRING MD (sign admit orders)

Name: _____ License#: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Information:

Patient Name: _____ DOB: _____

Address: _____Apt.#: _____

City: _____State: _____ Zip: _____

Phone # 1: _____ Phone # 2: _____

SSN: _____ Sex : M F Race: _____

Marital Status: S M D W Lives Alone: Y N

Face To Face Physician Encounter Documentation

I certify that this patient is under my care and that I, 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: _____/_____/_____ (Date visit occurred).

1.) 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. _____

Primary Diagnosis (related to reason for home care admission) _____

Secondary Diagnosis/Surgical Procedure: _____

Specific Orders: _____

2.) I certify that, based on my findings, the following services are medically necessary home health services.

❑ RN/LVN ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy

❑ Medical Social Worker ❑ Home Health Aide

3.) My clinical findings support the need for the above services because: _____

_____

_____

4.) Further, I certify that my clinical findings support that this patient is homebound because: _____

_____

Provider's Signature: _____ Date: _____

Requested Start of Care Date: _____/_____/_____

INSURANCE INFORMATION

Medicare #:_____

Insurance Company: _____ Policy #: _____

**(Please attach any additional orders, demographics, labs, etc that may be needed to admit patient to Home Health services)