Sphinx Home Health Care Referral/ Face-To-Face Form

Date: ____ /____ /_____ Patient Name: _____ Birth date: ___ /___ /____

Address: _____ City: _____ Zip: _____

Social Security #:_____ Phone #: (____) _____ - _____ Alt. Phone #: (____) _____ - _____

Emergency Contact Name: _____ Emergency Phone: (____) _____ - _____

Medicare #: _____ Other Insurances: _____

Diagnosis: _____ _____ _____

_____ _____ _____

Services Requested

☐RN ☐PT ☐OT ☐SLP ☐AIDE ☐MSW ☐Dietitian

Face-To-Face Attestation

I certify that this patient is under my care and that I, or a nurse practitioner / clinical nurse specialist /certified nurse midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirement with this patient on:

Date of face-to-face visit: ____ / ____ / _____ MM/DD/YYYY

Medical Condition: The encounter with the patient was directly related to the **following medical condition, which is the primary reason for home care:**

Clinical Findings In Support of Patient's Eligibility
Please provide a summary of **the clinical findings that support the patient's eligibility for home health services, including specific need for intermittent skilled nursing and/or therapy services.** The face-to face visit findings must be related to the primary reason for home health admission.

_____

_____

Statement of homebound status: I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient is homebound** (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or are infrequent OR of short duration when for other reasons) due to:_____

_____

Certifying Physician Name: _____Physician Phone # ::(____) _____ - _____

Certifying Physician Signature: _____Physician Fax # ::(____) _____ - _____

Date: _____ /____ /_____

Phone: (586)264-2400 | Fax: (586)264-2919 | www.sphinxhomecare.com

** NOTICE- The attached communication contains privileged and confidential information. If you are not the intended recipient, DO NOT read, copy, or disseminates this communication. Non-intended recipients are hereby placed on notice that any unauthorized disclosure, duplication, distribution, or taking of any action in reliance on the contents of these materials is expressly prohibited. If you have received this communication in error, please delete this information in its entirety and contact Sphinx Home Health Care at 586.264.2400. Also, please immediately notify the sender that you have received this communication in error **