



620 South Lake St. Suite 3
Leesburg, FL 34748
Office: 352-435-0101
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Physician Name: _____
Physician Address: _____

Physician Phone: _____

ADMISSION ORDER

Patient Name: _____ MR #: _____
Patient Address: _____
Date Effective: _____

EVALUATE PATIENT FOR HOME HEALTH SERVICES

Registered Nurse

REASON FOR EVALUATION

Skilled Observation and Evaluation Medication and Disease Process Instructions
Wound Care IV Therapy Injection Therapy SQ/IM Other

Signature of Nurse Receiving Orders

Date

Physician Signature

Date

Date Received: _____

Documentation of Face to Face Encounter Admission Order

Patient's Name: _____ MD Name: _____
MR #: _____ NPI: _____ phone: _____
Medicare #: _____ DOB: _____ Address: _____

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):

Month	Day	Year	Primary Diagnosis
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The encounter with the patient, diagnosis, was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

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

- Nursing Services
- Therapy Services: Physical Occupational Speech Respiratory
- Home Health Aide

Services to be provided: _____

Referred to the Home Health Agency: _____

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

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

Physician Signature _____

Date of Signature _____

SALUD HOME CARE

PHYSICIAN ORDER:

- INITIAL/ADMISSION ORDER
RECERTIFICATION ORDER
REINSTATEMENT ORDER
DISCHARGE ORDER
MODIFY/VERBAL ORDER

Order Date: _____

Sent/Faxed on: _____

Patient's Name: _____ Med. Record #: _____

SOC Date: _____ Cert. Period: _____ D/C Date: _____

Diagnosis: _____

Disciplines ordered/frequency: SN HHA PT OT ST MSW Other:

ORDERS/FREQUENCY/DURATION Nursing / Aide (Locator 21)

- N/A Observation/Assessment complete system, vital signs, complications:
Assess patient's response to new/changed meds and/or treatment/procedures
Teach new/changed medication regimen, side effects
Wound Care order:
Diabetes Management Insulin Dependent Non Insulin Dependent

- Order:
Report significant finding, monitoring: BP BS Anticoagulant Therapy Emergency Plan
Teaching/monitoring Nutritional Status, Hydration, Diet: Safety Precautions
Other:

Medication Management: See Medication Scheduled New Meds:

- Aide to Assist with ADL's, Personal Care Personal Hygiene Other:

ORDERS/FREQUENCY/DURATION Therapy (Locator 21)

- N/A PT ST OT evaluation (circle) Therapeutic exercises Balance/Coordination tech
Gait training/evaluation Assistive Device training Safety awareness/training
Pain Management/Control/Treatment Active ROM exercise Massage EMS
Transfer Mobility from to Home Exercise Program Other:

PT:
OT:
ST:

ORDERS/FREQUENCY/DURATION MSW (Locator 21)

- N/A Evaluation/Assess home situation Referral to Community Assess social/emotional factors
Financial Resources information ALF/Hospice/Nursing Home placement/referral
Other:

Clinical findings support the need for the above services:

Order verified/read-back by (Name/Signature/Title):

Date:

Physician Name: Address:

Phone:

UPIN #:

MD Signature: Date: