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 ☐ Fall precautions/prevention
☐ Teach new/changed medication regimen, side effects ☐ Pain assessment/management/treatment
☐ 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: _____

620 South Lake St. Suite 3
Leesburg, Fl 34748
Office: 352-435-0101
Fax: 352-435-0303

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

Patient's Name: _____
MR #: _____
Medicare #: _____ DOB: _____

MD Name: _____
UPIN No. _____
NPI: _____ phone: _____
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

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 <u>because</u>:
_____
_____
_____
_____

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 <u>or</u> infrequently or of short duration when for other reasons) <u>because</u>:
_____
_____
_____
_____

Physician Signature _____

Date of Signature_____

NOT ADMISSION DOCUMENTATION FORM:

(Do not bill)

Patient/Client: _____ HIC Number: _____

Physician: _____ MD Phone: _____

Pay Status: □ Medicare □ Medicaid □ HMO □ Private Insurance _____

□ Other: _____

Advance Beneficiary Notice delivery to patient? □ Yes □ No □ N/A

Reason for not admission: *(mark all that applies)*

□ Not homebound

□ Treatment will not improve patient's condition/disease

□ Refuse face to face encounter with physician

□ Service requested not medical necessary

□ Patient/Family refuse admission visit/services

□ Physician canceled initial admission/verbal order

□ Necessary drugs, medical equipment/devices for services not available

□ Not comply with Medicare/Medicaid/Insurance criteria for admission/services

□ Unable to contact with physician directly to verify orders/medications

□ Patient/Family/Physician elect another Agency

□ Physician do not comply with Face to Face documentation

□ Other: _____

Comment: _____
_____
_____

Report completed by (Name/Title): _____

Signature: _____ Date: _____

□ *Faxed to Physician on* _____