Wellspring Home Health Center
Referral Orders & Face-to-face Encounter
201 E Swanson Ave., Suite 7
Wasilla AK 99654
Office: (907) 357-3655 Fax: (907) 357-3656

PRIMARY PHYSICIAN SIGNING HOME HEALTH ORDERS

PHYSICIAN NAME		Date
ADDRESS		
CITY	STATE	ZIP
TELEPHONE # ( )	FAX ( )	
NPI #	LICENSE #	
OFFICE CONTACT	TELEPHONE #	

PATIENT INFORMATION

LAST NAME	FIRST NAME	
Sex ☐ Male ☐ Female	TELEPHONE #1 / TELEPHONE #2	
SERVICE ADDRESS		APT/BLDG#
CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY	
LANGUAGE SPOKEN BY PATIENT		
MENTAL HEALTH STATUS: ☐Oriented ☐Forgetful ☐Confused		
LIVES WITH ☐Caregiver ☐Family ☐Alone		
EMERGENCY CONTACT/RELATIONSHIP		
CONTACT TELEPHONE # DAY	EVENING	

INSURANCE INFORMATION

MEDICARE #	MEDICAID #
COMMERCIAL INSURANCE CARRIER	
POLICY #	
WC Y ☐ N ☐	NF Y ☐ N ☐

PRIMARY REASON FOR HOME CARE

Home Care Diagnosis

1. ______________________________________
2. ______________________________________
3. ______________________________________

***Mandatory: Please attach the following:**

1. Last office notes
2. Current list of meds
3. History & physical

Is the patient homebound? ☐Yes ☐No

Anticipated Start of Care Date
_____ / ____ / ______

Skilled Services

☐RN ☐ OT ☐ PT ☐ ST ☐ MSW
☐HHA
☐Palliative Care Program

Skilled Nursing

☐**Telemonitor: BP, P, O2 Sat, QD weight**
☐Teach CHF management self care ☐Teach COPD management self care ☐Teach HTN management self-care.
☐Diabetic Management self care
☐Medication Management
☐Nutrition/Hydration
☐Pain/Symptoms Management
☐Blood Draw Dates: ___________________________
☐Wound care **(Please attach written order/RX)**
☐Ostomy care and teaching **(please attach instructions)**
☐Urinary catheter: care & teaching **(please attach instructions)**
Size _____________Fr Size balloon _____________cc
Amount to install in balloon ______________________cc.
Date last changed _____________________________

Home Health Aide

☐ 1-3 visits/week x 9 weeks for assistance with personal care and ADL'S

Physical Therapy

Gait/Ambulatory Status
☐assistive device ☐walker ☐cane ☐bed bound ☐safety ☐home exercise program

I certify that a face-to-face encounter was performed on the above patient.

Encounter Date______/______/______By: __________________

I certify that the above stated patient is homebound and that upon completion of the FTF encounter, has a need for skilled nursing, PT, or ST, or OT or MSW services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician.

Physician Name (Print) ________________Date: __________

Physician Signature: ______________________________

Phone:___________________NPI:______________________