Wellspring Home Health Center
Referral Orders & Face-to-face Encounter
8815 S. Tacoma Way, Suite 120
Lakewood WA 98498
Office: (253) 625-7606 Fax: (253) 625-7079

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
☐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:_____