All areas of this form must be completed in **Narrative** form

Goshen Hospital

Goshen Homecare Order & Face to Face Encounter Form

Patient Name: _____DOB:_____

1. Homecare Order to evaluate and treat Date ordered: _____

- ☐ Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech/Language Therapy
- ☐ Medical Social Worker
- ☐ Telehealth
- ☐ Home Health Aide

2. Due to the following medical conditions_____

_____**this patient requires**

skilled services for _____

ie: Signs/Symptoms/Disease Management/Treatments

3. Primary Diagnoses: _____

See examples from "Unacceptable Primary Dx List" (cannot bill for F2F until primary dx is acceptable)

4. What makes the patient homebound?

_____

_____

_____

(Description of gait, balance, pain, activity intolerance, cognition, respiratory status, cardiovascular status, etc. Do not use taxing effort and lack of transportation.)

I certify this patient is under my care. I, or a Nurse Practitioner or a Physician's assistant working in collaboration with me, had a face to face encounter with this patient on:	**Month**	**Day**	**Year**
Physician Signature:			
Physician Printed Name:			
Physician that will follow in HHH and sign the POC:			
Nurse/Social worker completing form:	☐ Progress note attached with same physician and date of face to face		

*****Please fax completed form to Goshen Home Care at 574-364-2835**
or email GHHIntake@goshenhealth.com***