Atrium Health Navicent at Home
Face-to-Face Encounter

Patient Name:_____

Address: _____

Date of Birth: _____/_____/_____ **Encounter Date:** _____/_____/_____

The patient is under my care and I have authorized the services on this plan of care. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requries Home Health services.

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care: _____

_____

_____

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from the home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons). Clinical evidence to support homebound status is listed below (please select all that apply):

- ☐ Requires Assistive Device
- ☐ Poor Endurance
- ☐ Difficult & Taxing Effort to Leave Home
- ☐ Shortness of Breath
- ☐ Frequent Falls
- ☐ Post-Op Weakness
- ☐ Increased Weakness
- ☐ High Risk for Infection
- ☐ Decreased Mobility

I certify, based on my findings, the following services are medically necessary Home Health Services (indicate multiple if appropriate):

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Social Worker
- ☐ Home Health Aide

Printed Physician's Name:_____

Physician's Signature: _____ **Date:**_____/_____/_____

Thank you for choosing Atrium Health Navicent at Home for your patient's home health needs.

Please fax completed form to Central Intake @ 478-633-4031.