AIM HOME HEALTH INC.

3033 Ogden Ave. Suite #211
Lisle, IL 60532.
Tel: 630-946-6693 Fax:630-946-6775
Email. Contact@aimhh.com www.aimhh.com

Home Health Referral Form and Face to Face Documentation

PATIENT INFORMATION:

Name: _____ Primary Diagnosis: _____
Address: _____ _____
City: _____ State IL Zip: _____ _____
Phone: _____ Past Medical History: _____
DOB: _____ _____
Medicare #: _____ Allergies: _____
Medication List: _____
_____

PHYSICIAN ATTESTATION: To be filled out by physician who conducted **face- to- face encounter**, primary diagnosis, & Reason for Home Health Care Referral (List Medical Condition):

_____
_____

Clinical Findings to Support the Need for the Above Services:

_____
_____

Evidence Patient is Homebound: (ie., needs assistance for all activities, residual weakness, requires maximum assistance/ taxing effort to leave home, confusion/ unsafe to go out of home alone, severe SOB/SOB upon exertion, unable to safely leave home unassisted and/or any other clinical factors that affect homebound status).

_____
_____
_____

I certify that this patient is under my care and that I, a nurse practitioner or physician's assistant working with me, had face-to-face encounter that meets the physician encounter requirements with the patient on: **"Face to Face" Encounter"** (Last MD appt. Month/ Day/ Year) _____/ _____/ _____

The following services are medically necessary for Home Health Care: (Mark all that applies).

❑ Skilled Nurse to Evaluate for Home Care Needs ❑ Lab Orders: _____
❑ Physical Therapy Evaluation and Treatment ❑ Wound Care Orders: _____
❑ Occupational Therapy Evaluation and Treatment _____
❑ Speech Therapy Evaluation and Treatment ❑ Other: _____
❑ Medical Social Worker Evaluate for Community Resources _____

Physician Name: (printed) _____ Physician Signature: _____
Address: _____ City: _____ State: ___ Zip code: _____
NPI: _____
Physician Phone: _____ Physician Fax: _____