St. James Home Health, Inc.
16 Corning Avenue, Suite 246
Milpitas, CA 95035

Tel (408) 249-2475
Fax (510) 788-6079
intake@stjameshomehealth.com

PATIENT NAME _____ **DOB** _____

PHYSICIAN ORDER FOR HOME HEALTH CARE

- ☐ **Skilled Nursing**
- ☐ **Physical Therapy**
- ☐ **Occupational Therapy**
- ☐ **Speech Therapy**
- ☐ **Medical Social Services**
- ☐ **Home Health Aide Services**
- ☐ **Additional Orders:**

_____

☐ **Verbal Order Received / Date** _____ ☐ **New Order Request / Date** _____

Please **FAX** Patient Face Sheet, Demographic Information, Insurance, Medication Profile, Progress Notes, History and Physical.

PHYSICIAN FACE-TO-FACE ENCOUNTER

I certify that this Patient is under my care. I or a Nurse Practitioner or a Physician's Assistant, had a Face-To-Face encounter with the Patient on: _____
Month Day Year

The encounter with the Patient was in whole, or in part, for the following medical conditions, for which the Patient has been referred for Home Health Care Services:

To provide the following care / treatment (**required only when** Physician completing the Face-to-Face encounter documentation is different than the Physician completing the Plan-of-Care):

My clinical findings support the need for the above services **because**:

Further, I certify that my clinical findings support that this patient is homebound **because** (check all that apply)

- ☐ **Needs assistance for all activities**
- ☐ **Residual weakness**
- ☐ **Requires assistance to ambulate**
- ☐ **Confusion, unable to go out of home alone**
- ☐ **Other (specify)**
- ☐ **Unable to safely leave home unassisted**
- ☐ **Severe SOB, SOB upon exertion**
- ☐ **Dependent upon adaptive device(s)**
- ☐ **Medical restrictions**

Physician Signature _____ **Date of Signature** _____

Physician Printed Name _____