1. AGENCY:  
☐ Patient Preference  ☐ MD Preference  ☐ No Patient Preference  ☐ Insurance Requirement

2. DIAGNOSIS/SURGERY:

3. SERVICE:  ☐ Home Health  ☐ Home Infusion/Enteral

4. ORDERING PHYSICIAN:  
Phone ____________________________ (print physician’s name)

Subsequent orders and plan of care signed per Dr. ____________________________ Phone ____________________________

Follow-up Physician Appointment:

5. MEDICALLY NECESSARY SKILLED HOME HEALTH SERVICES:

☐ RN Visit frequency: ____________________________ and duration ____________________________ for:
  ☐ Physical observation and treatment
  ☐ Safety and mobility assessment and teaching
  ☐ Assess medication treatment and compliance
  ☐ Respiratory treatment/assessment
  ☐ Wound care (include instructions and supply list): ____________________________

☐ Ostomy care and teaching:

☐ Parenteral medications: ____________________________ Results to ____________________________

☐ Lab tests: ____________________________

☐ Suture/staple removal on: ____________________________

☐ Teaching/other: ____________________________

☐ Physical Therapy frequency: ____________________________ and duration ____________________________ for:
  ☐ Safety and mobility assessment and teaching
  ☐ Establish home exercise program
  ☐ Ambulation/transfer training/gait training
  ☐ Family/caregiver training
  ☐ Weight bearing status and/or precautions:

☐ Speech Therapy Evaluate and Treat Frequency: ____________________________ and duration ____________________________ for:
  ☐ Cognition
  ☐ Swallow

☐ Support Services: (In conjunction with one or more of the above orders)
  ☐ Occupational Therapist frequency ____________________________ duration ____________________________
  ☐ Home Health Aid frequency ____________________________ duration ____________________________
  ☐ Nutrition Counseling ☐ Medical Social Worker for: ____________________________
  ☐ Other: ____________________________

As attending Physician or allowed Non-Physician Provider (NPP) I certify that the patient is at least temporarily homebound secondary to ____________________________

as assessed during my face to face encounter on ____________________________ and requires the above ordered skilled care as a result of this clinical condition.

NOTE: An individual is considered “Homebound” if they have a condition due to an illness or injury that restricts the ability to leave his or her home except with the assistance of another individual or the aide of a supportive device (crutches, cane, wheelchair, walker) or a condition or injury such that leaving his or her home is medically contraindicated. The condition should be such that there exists a normal inability to leave home, that leaving the home requires a considerable and taxing effort.

- Home Health order, face sheet with CORRECT phone and discharge address, discharge summary (if available), medication list, H&Ps, all discharge instructions to be faxed to accepting Home Health agency.

NOTE: These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated, timed and signed below.
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>PHYSICIAN’S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Another brand of drug, identical in form and content, may be dispensed unless checked. ☐</td>
</tr>
</tbody>
</table>