Agency Address: **Agency Phone:**
Fax:

Home Health Orders

Patient Name:____DOB:_____/_____/_____

PCP/MD/NP/PA Following Home Health: ____

ICD-10 / Diagnosis: ____

- ❑ **RN EVALUATION AND TREATMENT**
  - ❑ Physical Assessment and Treatment / Teaching
  - ❑ Medication Management and Teaching
  - ❑ Disease Process Management and Education
  - ❑ Environmental/ Safety Assessment/Teaching
  - ❑ Other: ______________________
  - ❑ Cardiopulmonary Assessment / Monitoring / Treatment /Teaching
  - ❑ Wound Care / Incision Management Treatment/Teaching
  - ❑ Ostomy Care and Teaching
  - ❑ Lab Tests: ____________ Results To: ____________

- ❑ **PHYSICAL THERAPY EVALUATION AND TREATMENT**
  - ❑ Safety and Mobility Assessment and Teaching
  - ❑ Ambulation / Transfer / Gait / Stair Mobility Training
  - ❑ Manual therapy / Joint Mobilization / ROM / Strength & Stability Training
  - ❑ Balance Assessment and Intervention / Fall Prevention / Fall Recovery
  - ❑ Modalities for Pain Management
  - ❑ Weight Bearing status: NWB till:____/____/____PWB:____/____/____FWB as of:____/____/____

- ❑ **OCCUPATIONAL THERAPY EVALUATION AND TREATMENT**
  - ❑ Safety/Fall Prevention/Mobility Assessment and Teaching
  - ❑ IADL / ADL Training
  - ❑ Manual therapy / Joint Mobilization / ROM / Strength & Stability Training
  - ❑ Transfer / Equipment Assessment and Training / Energy Conservation
  - ❑ Modalities for Pain Management
  - ❑ Cognitive assessment

- ❑ **SPEECH THERAPY EVALUATION AND TREATMENT**
  - ❑ Dysphagia
  - ❑ Communication / Voice / Motor Speech / AAC
  - ❑ Cognitive assessment

- ❑ **MEDICAL SOCIAL WORKER FOR PSYCHOSOCIAL ASSESSMENT / INTERVENTION / COMMUNITY RESOURCES**

- ❑ **HOME HEALTH AIDE FOR PERSONAL CARE AND ASSISTANCE WITH ADLs**

______________________ ______________________________ ____/____/____

Provider's Printed Name **Provider's Signature** **Date**

Optimizing Home Health Referral Efficiency for your Patients

<table>
<tr><td rowspan="1">Face to Face Visit</td><td colspan="2">

- Within 90 days before or 30 days after home health admission
- Addresses primary reason for home health referral
- Addresses homebound status
- Signed and dated by provider (time stamped if e-signed)
- Allowed providers: MD/DO/PA/NP/DPM
- Performing provider must follow for home health unless patient was recently discharged from inpatient facility

</td></tr>
<tr><td>Homebound Status</td><td colspan="2">

- Needs supportive devices or a person to leave residence, OR
- Leaving home is medically contraindicated

-AND-

- Normal inability to leave the home and doing so is taxing

</td></tr>
<tr><td rowspan="2">Primary Diagnosis Code</td><td><u>Symptom codes</u>
Weakness
Unsteadiness
Pain</td><td><u>Underlying diagnosis</u>
Muscle atrophy
CVA
Muscle spasm</td></tr>
<tr><td><u>Unspecified codes</u>
Primary OA, unspecified site</td><td><u>More detail</u>
Add laterality
Specify site
Add acuity</td></tr>
<tr><td>Additional Helpful Documents</td><td colspan="2">

- Face Sheet/Demographics
- Progress Notes
- H&P or DC Summary
- Medication List
- Diagnosis List
- Therapy Notes

</td></tr>
</table>