# FACE-TO-FACE ENCOUNTER FOR HOME CARE

**To be filled out by the home care agency**

Patient D.O.B.: 12/13/1936

**QUALIFYING ENCOUNTER TYPE** *(check applicable type)*

☐ 1. Hospitalist provider conducted the face-to-face encounter and certification.
Date conducted _____ Provider's name: _____
Copy of face-to-face / certification documentation requested/obtained: ☐ Yes ☐ No

☑ 2. Face-to-face encounter conducted within 90 days of home care SOC.
Date conducted 11/28/2012 Provider's name: Dr, Song, Chaewon
Copy of face-to-face / certification documentation obtained: ☑ Yes ☐ No

☐ 3. Face-to-face encounter will be conducted within 30 days of the SOC.
SOC date: _____ Date of 30th day: _____
Date of scheduled visit: _____
Was physician's office contacted to verify appointment and purpose of appointment? ☐ Yes ☐ No
If **Yes** date contacted: _____ by whom: _____
If **No** explain: _____

Additional information: _____

**To be filled by physician conducting the initial certification face-to-face encounter**

**PHYSICIAN ATTESTATION**

Home Health Certifying Physician *(print name)*: Dr. Song, Chaewon

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on. Date: 11/28/2012

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 *(List medical condition)*:

Patient had episode of hypotenuse & deconditioning

My clinical findings support the need for the services listed below because:

Assess BP, report out range of BP, teaching of new medications for HTN. PT for therapeutic execise to oncrease functional mobility and gait training.

I certify that my clinical findings support that this patient is homebound* because:

Requires assistance to ambulate,SOB, unable to safely leave home unassisted.

*(*i.e., absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons.)*

I certify that the following home care services are medically necessary *(Check all that apply)*: ☑ Nursing ☑ Therapy

**Physician to sign and return within 2 days**

Physician's signature: _____ Date of signature: _____

| PART 1— To Physician (for signature) | PART 2— Clinical Record (temporary copy) |
|---|---|
| **PATIENT NAME (Last, First, Middle Initial)** | **ID #** |
| Cho Sungmook | 5835-03 |