VNA of Albany
The Perfect Balance of Healing & Home

Face to Face Encounter Form

Patient Name:_____ Patient DOB:_____
Date: _____

I. Orders for Qualifying Home Care Services Needed:

□ Skilled Nursing for:
- □ wound care
- □ medication management
- □ treatments (specify below)
- □ other_____

□ Speech Therapy for:
- □ restorative speech/language services
- □ other_____

□ Physical Therapy for:
- □ plan/implement therapeutic exercises
- □ therapeutic treatments (specify below)
- □ strengthening/gait training
- □ evaluate for OT
- □ other_____

Additional Services needed:
- □ Occupational Therapy for_____
- □ Medical Social Work for_____
- □ Home Health Aide for_____

II. Describe how the patient's clinical findings as seen during this encounter support the need for skilled home care services. Medical Condition and Clinical Findings:

_____
_____
_____
_____

III. Please indicate physician's clinical findings which support patient's homebound status and explain why patient's medical condition results in an inability to leave the home: *(Include for example: medical/surgical restrictions, physical limitations, cognitive or behavioral conditions, sensory deficits, immunological indicators)*

_____
_____
_____
_____

I certify that I (or the NP or PA working with me) had a face to face encounter with this patient on the above date. I certify that Dr. _____ has agreed to provide oversight in the community. I certify that I have written the plan of care that initiated this referral.

Date service requested to start: _____

Physician Name (print):_____

Physician Signature:_____ Date:_____
(*Must be MD/DO signature)