



**WellSpring Home Health Center Referral Orders and Face-to-face Encounter**

201 E. Swanson Avenue, Suite 7  
 Wasilla, Alaska 99654  
 Office: (907)357-3654/3655 Fax: (907)357-3656



PHYSICIAN SIGNING HOME CARE ORDERS	
PHYSICIAN NAME	Date
ADDRESS	
CITY	STATE ZIP
TELEPHONE # ( )	FAX ( )
NPI #	LICENSE #
OFFICE CONTACT	TELEPHONE #
PATIENT INFORMATION	
LAST NAME	FIRST NAME
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	TELEPHONE #1 TELEPHONE #2
SERVICE ADDRESS	APT/BLDG#
CITY	STATE ZIP
DATE OF BIRTH	SOCIAL SECURITY
LANGUAGE SPOKEN BY PATIENT	
MENTAL HEALTH STATUS: <input type="checkbox"/> Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused	
LIVES WITH <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Alone	
EMERGENCY CONTACT/RELATIONSHIP	
CONTACT TELEPHONE # DAY EVENING	
INSURANCE INFORMATION	
MEDICARE #	MEDICAID #
COMMERCIAL INSURANCE CARRIER	
POLICY #	
WC Y <input type="checkbox"/> N <input type="checkbox"/>	NF Y <input type="checkbox"/> N <input type="checkbox"/>

PRIMARY REASON FOR HOME CARE
<b>Home Care Diagnosis</b>
1. _____
2. _____
3. _____
<b>*Mandatory: Please attach the following:</b>
1. Last office notes
2. Current list of meds
3. History & physical
Is the patient homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Skilled Services</b>
<input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW
<input type="checkbox"/> Palliative Care Program
<b>Skilled Nursing</b>
<input type="checkbox"/> <b>Telemonitor: BP, P, O2 Sat, QD weight</b>
<input type="checkbox"/> Teach CHF management self care <input type="checkbox"/> Teach COPD management self care
<input type="checkbox"/> Teach HTN management self care
<input type="checkbox"/> Diabetic Management self care
<input type="checkbox"/> Medication Management
<input type="checkbox"/> Nutrition/Hydration
<input type="checkbox"/> Pain/Symptoms Management
<input type="checkbox"/> Blood Draw Dates: _____
<input type="checkbox"/> Wound care ( <b>Please attach written order/RX</b> )
<input type="checkbox"/> Ostomy care and teaching ( <b>please attach instructions</b> )
<input type="checkbox"/> Urinary catheter: care & teaching ( <b>please attach instructions</b> )
Size _____ Fr Size balloon _____ cc
Amount to install in balloon _____ cc
Date last changed _____
<b>Home Health Aide</b>
<input type="checkbox"/> 1-3 visits/week x 9 weeks for assistance with personal care and ADL'S
<b>Physical Therapy</b>
<b>Gait/Ambulatory Status</b>
<input type="checkbox"/> assistive device <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> bed bound <input type="checkbox"/> safety <input type="checkbox"/> home exercise program
<b>I certify that a face-to-face encounter was performed on the above patient.</b>
Encounter Date ____/____/____ By: _____
<i>I certify that the above stated patient is homebound and that upon completion of the FTF encounter, has a need for skilled nursing, PT, or ST, or OT or MSW services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician.</i>
Physician Name (Print) _____ Date: _____
Physician Signature: _____
Phone: _____ NPI: _____