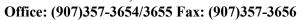


Wellspring Home Health Center Referral Orders and Face-to-face Encounter

201 E. Swanson Avenue, Suite 7 Wasilla, Alaska 99654





ORDERS			PRIMARY REASON FOR HOME CARE
PHYSICIAN NAME	ORDERS	Date	Home Care Diagnosis
			1
ADDRESS			
			2
CITY	STATE	ZIP	
			*Mandatory: Please attach the following:
TELEPHONE #	FAX		1. Last office notes
			2. Current list of meds
() NPI#	() LICENSE #		3. History & physical
	EIGEINGE II		Is the patient homebound? □Yes □No
OFFICE CONTACT	TELEPHONE #		Skilled Services
OFFICE CONTACT	TELEFTIONE #		□RN □PT □OT □ST □MSW
			□Palliative Care Program
PATIEN	NT INFORMATION	J	Skilled Nursing
			□Telemonitor: BP, P, O2 Sat, QD weight □Teach CHF management self care □Teach COPD manage
LAST NAME FIRST NAME		ME	self care DTeach HTN management self care
			□Diabetic Management self care
☐ Male Sex	TELEPHONE #1		□Medication Management
☐ Female	TELEPHONE #2		□Nutrition/Hydration
SERVICE ADDRESS		APT/BLDG#	□Pain/Symptoms Management
			□Blood Draw Dates: □Wound care (Please attach written order/RX)
CITY STATE ZIP		ZIP	☐Ostomy care and teaching (please attach instructions)
			☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
DATE OF BIRTH SOCIAL SECURITY			SizeFr Size ballooncc
			Amount to install in ballooncc
LANGUAGE SPOKEN B	BY PATIENT		Date last changed
			Home Health Aide
MENTAL HEALTH STATUS:			☐ 1-3 visits/week x 9 weeks for assistance with personal care and ADL
			Physical Therapy
□Oriented □Forgetful □Confused			Gait/Ambulatory Status ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
LIVES WITH C	aregiver □Family [⊐Alone	exercise program
EMEDOENCY CONTAC	CT/RELATIONSHIP		Skerelee program
EWERGENCY CONTAC	71/RELATIONSHIP		I certify that a face-to-face encounter was performed on the above patient.
CONTACT TELEPLICAL	- µ		Encounter Date/By:
CONTACT TELEPHONE	= #		Enounter Bate
DAY EVENING			I certify that the above stated patient is homebound and that upon
	NCE INFORMATION	ON	completion of the FTF encounter, has a need for skilled nursing,
MEDICARE #	MEDICAID#		or ST, or OT or MSW services in their home for their current
			diagnosis as outlined in their initial plan of care. These services
COMMERCIAL INSURA	NCE CARRIER		continue to be monitored by myself or another physician.
POLICY#			Physician Name (Print)Date:
			Phonisian Cinnature
WC Y D N D	NE VE		Physician Signature:
	NF Y□	N□	