TRANSITION HOME HEALTH PARTNERS, LLC

6200 SCHAEFER RD, STE 100
PHONE : (313) 945–6650 FAX : (313) 945–6659

PHYSICIAN ORDER AND FACE TO FACE ENCOUNTER

Please complete the following information and fax to Transition Home Health Partners, LLC. Patient will be contacted same business day, and assessed by our professional staff within 24-48 hours.

☐ VERBAL ORDER TAKEN BY : _____ DATE : _____/_____/_____

PATIENT INFORMATION

FACE TO FACE ENCOUNTER: _____/_____/_____

Name			
Address		DOB	_____/_____/_____
		Gender	☐ Male ☐ Female
		Medicare #	
		Other Carrier	
Phone	( ) _____ - _____	Insurance #	

MEDICAL INFORMATION

Medical diagnoses/Medical findings/Condition for services

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

HOMEBOUND REASON

- ☐ Residual weakness
- ☐ Required assistance/taxing effort to leave home
- ☐ Need assistance with all activities
- ☐ Unable to safely leave home unassisted
- ☐ Severe SOB, SOB upon exertion
- ☐ Confusion, unsafe to go out of home alone
- ☐ Use of assistive device
- ☐ Others:_____

PHYSICIAN ORDERED SERVICES

☐ Skilled Nursing	☐ Physical Therapy	☐ Medical Social Worker	☐ Speech Language Pathologist
☐ Home Health Aide	☐ Occupational Therapy	☐ Registered Dietitian	☐ Medical equipment required

I certify that the above patient is under my care, meets face to face encounter requirements, and requires the above home health care services. I further certify that this patient is home bound, i.e. absence from home requires considerable and taxing effort and has medical necessity, and is confined to his/her home.

PHYSICIAN INFORMATION

Name : _____ Phone : ( ) _____-_____ Fax ( ) _____-_____

Address : _____

Signature: _____