



HAVEN HOME HEALTH, LLC
Experience the difference in patient care!



PHYSICIAN CERTIFICATION OF FACE TO FACE ENCOUNTER

PATIENT

Last Name: _____ First Name: _____ MI: _____
 Date of Birth ____/____/____ Medicare Number: _____
 Phone Number: _____

Date of Last Patient Face to Face Encounter: _____

Clinical Findings supporting the need for skilled nursing and/or therapy home health:

Clinical Findings Supporting Homebound Status: _____

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care or will be transferred to the care of his/her physician and I have authorized home health services.

ORDERS

1. Evaluate Patient for Home Care Services
2. Disciplines: SN PT OT ST MSW HHA
3. Orders: _____

Physician Name: _____ Office Contact: _____

Physician Signature: _____ Date: _____

Telephone: _____ Fax: _____

Dallas
 Tel: 972-644-3000
 Fax: 972-644-3040

Denton
 Tel: 940-497-6444
 Fax: 940-497-6455

Ennis
 Tel: 972-878-0303
 Fax: 972-878-0055

Fort Worth
 Tel: 817-507-2200
 Fax: 817-492-0099

Greenville
 Tel: 903-454-4444
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