Patient Name: _____ _____
First Last

Pt. DOB: _____ (mm/dd/yyyy)

NIRVANA HEALTH SERVICES, INC.
Celebrating Decades of Outstanding Home Health Services

Face-to-Face Encounter

All fields are required.

Physician Attestation

I certify that this patient is under my care and that I, or the referring physician or a nurse practitioner/clinical nurse specialist/ certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, have reviewed and incorporated the referrals/orders, labs and/or clinical notes from the hospital, into the physician's medical records for this patient and had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with this patient on:

Date of In-Person Visit: _____

Diagnosis (Structural Impairment)

The encounter with the patient was directly related to the **following medical condition**, which is the **primary reason for home health care**:

Statement of Homebound Status

I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient meets Both Criteria 1 (Activity Limitation) AND Criteria 2 (Functional Impairment) for homebound status due to**:

Activity Limitation Criteria 1

Requiring assistance of:

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Wheelchair
- ☐ Special transportation
- ☐ Assistance of another person
- ☐ Other: _____

☐ **And/Or** Patient's health or illness could get worse if they leave their home.

☐ **And/Or** Other: _____

AND

Functional Impairment Criteria 2

☐ There is a normal inability to leave the home
And Leaving the home requires a considerable and taxing effort

☐ Other: _____

Explained by: _____

Rationale/Clinical Findings in Support of Patient's Eligibility

The following **clinical findings** established during this Face-to-Face visit, **supports the patient's eligibility for home health services** and are the primary rationale for home health admission:

Rationale

Physical Therapy

☐ PT Evaluation and Treatment recommendations for:

- ☐ Cardiovascular Rehab
- ☐ Gait/Ambulation Training
- ☐ Lymphedema Therapy
- ☐ Neurological Rehab
- ☐ Orthopedic Rehab
- ☐ Vestibular/Balance Rehab
- ☐ Other _____

Skilled Nursing

☐ RN Evaluation and Treatment recommendations for:

- ☐ Cardiac Care
- ☐ Wound Care
- ☐ Diabetic Teaching
- ☐ IV Therapy
- ☐ Pulmonary Care
- ☐ Neurological Care
- ☐ Endocrine Care
- ☐ Other _____

Occupational Therapy

☐ OT Evaluation and Treatment recommendations for:

- ☐ ADL's
- ☐ Dressing
- ☐ Grooming
- ☐ Other _____

Speech Therapy

☐ ST Evaluation and Treatment recommendations for:

- ☐ Aphasia
- ☐ Dysphasia
- ☐ Other _____

Additional Info:

Certifying Physician Signature & Date	**Certifying Physician Name / Credentials (MD, DO, DPM)**

Nirvana Health Services, Inc. ♦ 220 East Central Parkway , Suite 2070 ♦ Altamonte Springs, FL 32701
Tel: (407) 647-5008 ♦ Fax: (407) 647-5299