ACACIA
HOME HEALTH SERVICES
L.A. County → Phn: (818) 241-2200 // Fax: (818) 241-0671
Orange County → Phn: (949) 335-5515 // Fax: (949) 335-5519

FACE-TO-FACE ENCOUNTER INTAKE / REFERRAL FORM

Patient Name: _____ Date of Birth _____ Gender: ____ MR_____

Patient Address: _____ City/State/Zip: _____ Tel. #_____

Emergency Contact: _____ Relationship _____ Contact # -> _____

Medicare No.: _____ Part A ____ Part B_____ Medicaid/Insurance No.: _____

Hospital/SNF/Rehab Info _____Inpatient Stay Date: From:_____ To:_____ Allergies:_____

Physician Name:_____ NPI/License #: _____ Tel # _____

Physician Address _____ City/State/Zip: _____Fax #_____

I certify that this patient is under my care and that I, a nurse practitioner, or physicians' assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on:

____/____/____.
MONTH / DAY / YEAR

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (MEDICAL CONDITION(S)/DIAGNOSIS):

DIAGNOSIS:	**DIAGNOSIS CONTINUED:**

I certify that, based on my finding, the following services are medically necessary home health services:

☐ NURSING ☐ PHYSICAL THERAPY ☐ SPEECH LANGUAGE PATHOLOGY
☐ CHHA ☐ OCCUPATOINAL THERAPY ☐ SOCIAL WORKER

My clinical findings support the need for the above services because: _____

_____

_____

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons, religious services OR are infrequent or of short duration when for other reasons) due to:

_____

_____

Physician Signature _____ **Date** ____/____/_____

Referral Accepted by: (Print Name/Title) _____ Sign_____ Date ____/____/_____