1100 W. Pioneer Pkwy, Arlington, TX 76013 | (817) 461-3341 | Fax (817) 795-7074

Patient Name _____

Address _____

Phone Number _____

Diagnosis _____

ORDERS

I certify that, based on my findings, the following services are medically necessary home health services because: (Check all that apply)

- ☐ Evaluate and Treat _____
- ☐ Nursing _____
- ☐ Home Health Aide _____
- ☐ Physical Therapy _____
- ☐ Occupational Therapy _____
- ☐ Speech Therapy _____

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 or religious services or infrequently or of short duration when for other reasons) because: _____

_____

_____

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

Physician's Name (Printed) _____

Physician's Signature: _____ Date: _____