

PHYSICIAN'S HOME HEALTH CERTIFICATION

1. Certification Period

From: _____ To: _____

2. Patient's Name and Address

5. Physician's Name and Address

3. Date of Birth: _____ Sex M F

4. Policy No.

6. Physician's Tax I.D. No.

7. ICD-9-CM	Principal Diagnosis	Date
8. ICD-9-CM	Other Pertinent Diagnoses	Date

9. Hospital Confinement for which Subsequent Home Health Care is required.

A. From: _____
 To: _____
 B. Name of Hospital and Address

10. Can the patient perform any of the following Activities of Daily Living (ADL's) without the assistance of another person?

- | | | | |
|----|--------------------------|--------------------------|--|
| | <u>YES</u> | <u>NO</u> | |
| A. | <input type="checkbox"/> | <input type="checkbox"/> | Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps); |
| B. | <input type="checkbox"/> | <input type="checkbox"/> | Dressing (tying shoes, buttoning buttons or clasps); |
| C. | <input type="checkbox"/> | <input type="checkbox"/> | Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach); |
| D. | <input type="checkbox"/> | <input type="checkbox"/> | Toileting (maintaining adequate bathroom hygiene and toilet habits); or |
| E. | <input type="checkbox"/> | <input type="checkbox"/> | Transferring to or from bed or chair |

If any of the above are answered "NO," please furnish test results.

11. Does the patient require continuous supervision and assistance due to a Cognitive Impairment (a deficiency in the ability to think, perceive, reason, and/or remember, which has been evaluated and measured through clinical evidence and standardized tests)? YES NO
 If "YES," please furnish test results.

12. Home health services performed:

- Skilled Nursing (R.N.)
- General Nursing (L.P.N. or L.V.N.)
- Physical Therapy
- Speech Pathology
- Occupational Therapy
- Chemotherapy Specialist Services
- Enterostomal Therapy
- Respiration Therapy
- Medical Social Services
- Home Health Care Aide (any individual, other than a member of the patient's immediate family, working under the supervision of an R.N., who is qualified, by training and experience, to provide assistance with the Activities of Daily Living listed in 10 above and has been certified by the appropriate regulatory authority).
- Other (specify) _____

13. Other Remarks:

14. I certify recertify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.

15. Certifying Physician's Signature

Date Signed