BAKER REHAB GROUP

COMMITTED TO EXCELLENCE

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Patient Name (Printed): _____

Patient Date of Birth: Today's Date:

Face-to-Face Attestation:

I certify that this patient is under my care and a face-to-face encounter with the patient was completed on _____(date). The encounter with the patient was, in whole or in part, for the following medical conditions, which are the reasons for Home Health Care (please list medical contions(s))

Based on the clinical findings, I certify that the following services are medically necessary. My clinical findings support the need for the ordered services because: (check all that apply)

☐ **Skilled Nursing Orders:**
- ☐ Medication Management
- ☐ Disease Management
- ☐ Wound Management
- ☐ Lab Work

☐ **Physical Therapy Orders:**
- ☐ Evaluation and Treatment

☐ **Speech Therapy Orders:**
- ☐ Evaluation and Treatment

☐ **Occupational Therapy Orders:**
- ☐ Evaluation and Treatment

☐ **Comprehensive Driving Evaluation**
- ☐ Clinical/Behind the Wheel Evaluation

Please select the following services that are needed : (check all that apply)

- ☐ Therapeutic devices to perform functional mobility
- ☐ Restore/Improve communication/cognitive ability
- ☐ Improve functional speech
- ☐ Resore safe Ambulation, balance transfers
- ☐ Weight Bearing Status:
- ☐ Improve functional mobility to perform ADLs/IADLs
- ☐ Restore muscle strength to improve functional mobility
- ☐ Restore/Improve swallowing function
- ☐ Educate caregiver/patient in safety, mobility technique and Equipment needs

Furthermore, I certify that my clinical findings support that this patient is homebound because the patient experiences considerable and taxing effort when leaving the home due to: (check all that apply)

☐ **The patient has limited ambulation and requires assistance to safety leave the home due to:**

- ☐ Pain
- ☐ Stroke
- ☐ Weakness
- ☐ Bedbound
- ☐ Walker
- ☐ Surgery
- ☐ Wound
- ☐ Dysphea
- ☐ Walker
- ☐ Cane
- ☐ Crutches
- ☐ Wheelchair
- ☐ Fall Risk
- ☐ Cardiac Problems
- ☐ Dementia/Confusion
- ☐ Managing stairs/door
- ☐ Fear of Leaving Home

☐ **The patient has activity restrictions/medical restrictions and is confined to the home due to:**

- ☐ Dementia/Confusion
- ☐ Fear of leaving the home
- ☐ Wound restrictions
- ☐ Cardio-pulmonary status
- ☐ Immune system compromised

The findings from this face-to-face encounter have been communicated with this patient's physician, who will be responsible for, and periodically reviewing this patient's home health plan of care.

Physician Name (Printed) _____ Physician Signature _____ Date _____

With this form, please include:

Physicial Order for Requested Services----Patient Demographic Information----Patient Insurance Information

Please fax this information to Baker Rehab Group at 301-668-2202. For questions, please call BRG at 866-727-3422