Home Care

FirstHealth Home Care serves patients in Moore, Richmond, Montgomery, Lee, Hoke and Scotland counties.

Home Care Patient Qualifications:

- Physician's referral
- Homebound (trips to outside medical care would be taxing and difficult)
- In need of skilled nursing or therapy on an intermittent basis

Direct Nursing Care

- Adult Nursing
- Disease/Medication Management & Education
- IV Infusion Therapy
- Wound Care
- Ostomy Care
- TeleHealth Monitoring
- Teaching Caregivers and Supervision of Care

Physical Therapy/Occupational Therapy

- Orthopedic/Neurological Rehabilitation
- Post-Hospitalization Rehabilitation
- Home Safety / Falls Prevention
- OTAGO Falls Prevention Program
- Life Management Skills Assessment & Training
- Urinary Incontinence Program

Social Worker

- Long-term Planning
- Referral to Community Resources
- Assistance with Financial Concerns

Home Health Aides

- Assistance with Personal Care

Main Phone Number: **(800) 876-2212**

768-132-18

Home Care

Please fax all information to (910) 255-0390

FAST FAX REFERRAL

REFERRAL CHECKLIST

- ❒ **Fast fax referral form**
- ❒ **Recent clinical information**
- ❒ **Current medication list**
- ❒ **Face-to-face encounter**

Referral Contact

Referral Facility:

Physician

( ) ( )

Phone Fax

M.D. ORDERS

Disciplines: RN ___ PT ___ OT ___ HHA ___ MSW ___

Diagnosis

M.D. SIGNATURE

Call FirstHealth Home Care at (800) 876-2212 for questions regarding our services, services area or patient eligibility.

PLEASE COMPLETE THIS SECTION OR FAX PATIENT DEMOGRAPHIC SHEET.

Patient's Name	Insurance Payor
Address	Policy #
City County State ZIP	Insurance Phone No.
Phone Number Date of Birth Sex	Medicare
Emergency Contact (outside of the home)	Medicaid

Home Care to complete this section

Date patient to be seen Central Intake Signature

HOME CARE

(800) 876-2212

www.firsthealth.org

768-132-18

Physician Documentation of Face to Face Encounter for Medicare Home Health Patient

Patient Name: ______________________________

Date of Birth: ______________________________ (month, day, year)

Date of Face to Face Encounter: 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 face-to-face encounter requirements with this patient on:

______________________________ (month, day, year)

Medical Condition: 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 (list medical condition):

____

Medical Necessity: I certify, based on my findings, that the following services are medically necessary home health services (check all that apply) ❑ Skilled Nursing ❑ Physical Therapy ❑ Occupational Therapy ❑ Home Health Aid ❑ Social Worker

To provide the following care/treatments: *(Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care)*

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Clinical Findings: My clinical findings support the need for the above services because:

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____

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Homebound Status: 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 infrequent or of short duration when for other reasons)* because:

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____

Physician Signature ______________________________

Date of Signature ______________________________ (month, day, year)

Physician Printed Name ______________________________

FirstHealth Home Care • 181 Westgate Drive, Suite A • West End, NC 27376 • fax 910-255-0390 • ph 800-876-2212

FirstHealth Home Care • 928 S. Long Street • Rockingham, NC 28379 • fax 910-255-0390 • ph 800-876-2212

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