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
- OTAGO Falls Prevention Program
- Home Safety / Falls Prevention
- 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**

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**
- ❍ **History & Physical**
- ❍ **Discharge Summary**
- ❍ **Operative Report**
- ❍ **Consultation Notes**

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

Address

City County State ZIP

Phone Number Date of Birth Sex

Emergency Contact (outside of the home)

Insurance Payor

Policy #

Insurance Phone No.

Medicare

Medicaid

Home Care to complete this section

Date patient to be seen Central Intake Signature

FirstHealth
HOME CARE

(800) 876-2212

www.firsthealth.org

670-132-19

Physician documentation of face-to-face encounter for Medicare home health patient

FirstHealth HOME CARE

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 the 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 service (*check all that apply*):

❍ Skilled Nursing ❍ Physical Therapy ❍ Home Health Aide
❍ Occupational Therapy ❍ 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).*

_____

_____

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

_____

_____

_____

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 reason or religious services of infrequent or of short duration when for other reasons*) because:

_____

_____

_____

Physician Signature: _____

Date of Signature: _____ (month, day, year)

Physician Printed Name: _____

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