Optimal Care, Inc.
Call us first: 248.723.9613
Fax referrals: 248.723.9615
Same day admissions
On call 24/7

Patient: ______________________________ **DOB:** ______________

Face to Face Encounter must be 90-days prior or 30-days after the SOC

Encounter date _____ /_____ /_____ and primary diagnosis ______________________________

Progress note must contain the Medcare qualifying diagnosis and a supporting narrative of home care need & homebound status.

☐ SKILLED NURSING: Disease management to address the following conditions

- ☐ CHF
- ☐ Effect(s) of CVA ______________
- ☐ HTN
- ☐ COPD
- ☐ Respiratory Infection (PN, URI)
- ☐ COVID-19
- ☐ Diabetes with ______________
- ☐ Neuropathy, type ______________
- ☐ PVD
- ☐ UTI
- ☐ Catheter Management
- ☐ OA (primary) ______________
- ☐ Pain r/t ______________
- ☐ Anemia
- ☐ Alzheimer's
- ☐ Dementia or Dementia w/behaviors
- ☐ Parkinson's
- ☐ Depression
- ☐ Anxiety
- ☐ PSYCH NURSE EVAL
- ☐ Wound Care: ☐ Pressure ulcer ☐ Traumatic wound ☐ Stasis ulcer ☐ Infection ☐ Other______________
- ☐ Other Qualifying Diagnoses: ______________________________

☐ PHYSICAL THERAPY: Functional declines due to below ☐ OCCUPATIONAL THERAPY

- ☐ Sarcopenia
- ☐ Parkinsons
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Chronic Pain
- ☐ CHF
- ☐ Infection ______________
- ☐ Diabetes with ______________
- ☐ PVD
- ☐ Neuropathy
- ☐ Lymphedema Therapy
- ☐ COPD
- ☐ OA of ______________
- ☐ Spinal Stenosis of ______________
- ☐ Degen. Disc Disease of ________
- ☐ Fracture of ______________
- ☐ Effect(s) of CVA ______________
- ☐ COVID-19
- ☐ Other Qualifying Diagnoses: ______________________________

☐ SPEECH THERAPY: Evaluate and treat for the following

- ☐ Dysphagia/difficulty swallowing
- ☐ Aphasia/difficulty speaking
- ☐ Other ______________

☐ MSW ☐ Home Health Aide ☐ Registered Dietitian ☐ Spiritual Care

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy. The patient is under my care, and I have authorized services related to this plan of care and will periodically review the plan. The patient had, or will have, a face-to-face encounter with an allowed provider type and the encounter was, or will be, related to the primary reason for home health care.

Provider Signature: ______________________________ Date: ______________

Provider Name: ______________________________ Phone: ______________

***Please attach patient demographics including insurance, corresponding progress note, and medication list.**

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