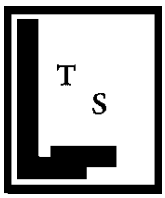
Rebecca Summers, OT, CLT-LANA, CSR
Licensed Occupational Therapist
Certified Lymphedema Therapist
Lymphology Association of North America-certified



Lymphedema Therapy Source, PLLC
2410 Luna Rd, Suite 248
Carrollton, Texas 75006
214-422-8265
214-614-9352 fax

Physician's Script (Homebound / Home Health)

PATIENT INFORMATION		**PHYSICIAN INFORMATION**	
Patient's Name:		Physician Name:	
Medicare/Medicaid No.:		NPI:	
Date of Birth:		Referral Date:	
Sex:		Requested Start Date:	
Address:		Address:	
City/Zip:		City/Zip:	
Phone:		Phone:	
Emergency Contact:		Office Contact:	
Emergency Relationship:		Phone:	
Emergency Phone:		Facility D/C Date:	

FACE-TO-FACE ENCOUNTER

I certify this patient is under my care & that I (or a nurse practitioner or physician's assistant working with me) had a face-to-face encounter with this patient that meets the CMS requirements on this date:

_____/_____/_____

DATE OF SCHEDULED APPOINTMENT (If Face-to-Face has not occurred): _____/_____/_____

This encounter was in whole or in part due to the following medical condition (which is the Primary Diagnosis & reason for home health care).

Cardiac	Orthopedic	Neurological	Pulmonary	Vascular	Additional
CHF__	Hip ___	CVA__	COPD__	Diabetes__	Infection___
MI__	Knee___	Parkinson's__	Pneumonia__	CVI___	Cancer___
HTN__	Shoulder___	Neuropathy__	Asthma__	DVT___	Lymphedema___
				Wounds__	Renal Failure ___

Other: _____

Secondary Diagnosis: _____

I certify, based on my findings, the following home health services are medically necessary for this patient (mark all that apply):

*SN ____ *ST ____ *PT ____ *OT ____ ***Lymphedema (OT/PT) ____**

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

(Example: Care & service is medically reasonable & necessary due to debility making leaving the house very taxing without direct supervision & assistance).

Additional Services: MSW ____ HHA ____ Wound Care ___ **Lab Draw** ____ Specific Orders: _____

NOTE: For patients with a history of CHF or renal impairment who are referred for bilateral leg swelling, we may request BNP & BUN/CREATININE to ensure tolerance. A significant amount of fluid can be returned to the venous angle causing medical decline. Aside from symptoms, we have no other way to monitor this population. Without this, we may not be able to treat your patient.

I certify that my clinical findings support that this patient is homebound (i.e. absences from home are a considerable & taxing effort, are for medical reasons or religious services, are infrequent or of short duration when for other reasons) because: _____

_____

Physician Signature: _____ Date: _____