Suggested Voluntary Electronic Clinical Template Elements of a
Progress Note Documenting a
Face-to-Face Examination for Home Health Services
DRAFT v4.1 (01/28/15)

A.

1. Patient Information
   a. First Name: _____
   b. Last Name: _____
   c. Date of Birth: _____
2. Provider Information
   d. First Name: _____
   e. Last Name: _____
   f. Credentials: ☐ MD/DO/DP
      ☐ PA/NP (required concurrence and co-signature by MD/DO/DP)
      ☐ Other:_____
   g. Address where exam is taking place: _____
   h. NPI: _____

B. (Cannot be completed by the Home Health Agency (HHA) or anyone with a financial relationship to the HHA

1. Enter **date** of patient visit ___/___/____

2. Subjective Information (chief complaint patient history)

_____
_____
_____

3. Objective Information (constitutional data, physical examination findings, test results)

_____
_____
_____

4. Assessment

_____
_____
_____

5. Is the patient **homebound**?

☐ **Yes.** This patient is homebound because an illness or injury renders him/her normally unable to leave home **except with the assistance of another individual and leaving the home requires a considerable and taxing effort.** (proceed to question 6)

☐ Yes. This patient is homebound because an illness or injury renders him/her normally unable to leave home **except with the assistance or aid of a supportive device and leaving the home requires a considerable and taxing effort**. (proceed to question 7)

☐ Yes. This patient is homebound because an illness or injury renders him/ her normally unable to leave home as it is **medically contraindicated and leaving the home requires a considerable and taxing effort.** (proceed to question 8)

☐ No. This patient can leave home without assistance and it is not medically contraindicated for him/her to do so. (HHA Services are NOT covered by Medicare for this patient.

6. **Why** does the patient require another individual to leave home?

(Please be specific. Do NOT simply state: "considerable and taxing effort," "gait abnormality," "weakness," or "unable to drive car", etc. Include **functional limitations** resulting from recent **surgical procedures** and/or any **medical restrictions**. Include if the patient is homebound because **their immune status is compromised** due to chemotherapy. Describe any other clinical issues that are impeding the patient's ability to leave home unassisted by another individual. Identify any **structural barriers**, such as stairs required to enter or exit the home. Include any **psychological/cognitive issues** that prevent the patient from leaving home with the assistance of another individual.)

The patient needs the assistance of **another individual** to leave home because:

_____

_____

_____

_____

(if the patient requires skilled **nursing services**, proceed to question 9)

(if the patient requires skilled **physical therapy** services, proceed to question 10)

(if the patient requires skilled **occupational therapy** services, proceed to question 11)

(if the patient requires skilled **speech language pathology** services, proceed to question 12)

(if the patient requires **other** skilled services, proceed to question 13)

7a. What supportive device does the patient require to leave home?

☐ a cane
☐ walker
☐ wheelchair
☐ other :_____

7b. Why does the patient require a supportive device to leave home?

(Please be specific. Do NOT simply state: "considerable and taxing effort," "gait abnormality," "weakness," or "unable to drive car", etc. Include **functional limitations** resulting from recent **surgical procedures** and/or any **medical restrictions**. Include if the patient is homebound because **their immune status is compromised** due to chemotherapy. Describe any other clinical issues that are impeding the patient's ability to leave home unassisted by a supportive device. Identify any **structural barriers**, such as stairs required to enter or exit the home. Include any **psychological/cognitive issues** that prevent the patient from leaving home with the assistance of a supportive device.)

The patient needs the assistance of a **supportive device** to leave home because:

_____

_____

_____

_____

(if the patient requires skilled **nursing services**, proceed to question 9)

(if the patient requires skilled **physical therapy** services, proceed to question 10)

(if the patient requires skilled **occupational therapy** services, proceed to question 11)

(if the patient requires skilled **speech language pathology** services, proceed to question 12)

(if the patient requires **other** skilled services, proceed to question 13)

8. Why is it medically contraindicated for this patient to leave home?

(Please be specific. Do NOT simply state: "considerable and taxing effort," "gait abnormality," "weakness," or "unable to drive car", etc. Include **functional limitations** resulting from recent **surgical procedures** and/or any **medical restrictions**. Include if the patient is homebound because **their immune status is compromised** due to chemotherapy. Describe any other clinical issues that are impeding the patient's ability to leave home unassisted by another individual. Identify any **structural barriers**, such as stairs required to enter or exit the home. Include any **psychological/cognitive issues** that prevent the patient from leaving home with the assistance of another individual.)

It is **medically contraindicated** for this patient to leave home because:

_____
_____
_____
_____

(if the patient requires skilled **nursing services**, proceed to question 9)
(if the patient requires skilled **physical therapy** services, proceed to question 10)
(if the patient requires skilled **occupational therapy** services, proceed to question 11)
(if the patient requires skilled **speech language pathology** services, proceed to question 12)
(if the patient requires **other** skilled services, proceed to question 13)

9. Why does the patient need skilled **nursing** care?

The patient requires skilled nursing services to:

☐ Teach/train the patient or family to: _____

☐ Observe/assess the following condition (describe why there is a reasonable potential for a future complication or acute episode. Observation and assessment by a nurse is not reasonable and necessary where fluctuating signs and symptoms are part of a longstanding pattern of the patient's condition):_____
_____

☐ Administer the following medications that the patient, family, or caregiver cannot safely administer:_____
_____
_____

This medication is being administered:

- ☐ IV
- ☐ IM
- ☐ SQ
- ☐ Orally. Skilled observation and assessment of oral administration is required because:_____

☐ Administer infusion therapy that the patient, family or caregiver cannot safely administer.

☐ Administer tube feedings that the patient, family, or caregiver cannot safely administer.

- ☐ Perform skilled wound care, catheter, and ostomy care that the patient, family or caregiver cannot safely administer
- ☐ Provide NG tube feeding and tracheostomy aspiration/care that the patient or family, or caregiver cannot safely administer.
- ☐ Provide NG tube feeding that the patient, family, or caregiver cannot safely administer.
- ☐ Conduct psychiatric evaluation and psychotherapy (must be provided by a psychiatrically trained nurse)
- ☐ Provide rehabilitation nursing care
- ☐ Other:_____
  _____
  _____

Certifying physician's signature: _____Date__/__/_____

10. Why does the patient need skilled **physical therapy** services?

The patient requires physical therapy services to:

- ☐ Restore patient function.
- ☐ Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy) _____
  _____
- ☐ The patient does NOT need physical therapy.

11. Why does the patient needs skilled **occupational therapy** services

The patient requires occupational therapy services to:

- ☐ Restore patient function
- ☐ Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy) _____
  _____
- ☐ The patient does NOT need occupational therapy.

12. Why does the patient **speech-language pathology** services?

The patient requires speech language pathology services to:

☐ Restore patient function

☐ Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy) _____
_____

☐ The patient does NOT need speech language pathology services.

13. Why does the patient **other** services (e.g., home health aide, medical services etc.)?

The patient requires other services (describe) _____to:
_____
_____

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PROVIDER:

NAME: _____ TITLE: _____
Employer:_____

C. Provider Signature/Date

PROVIDER'S SIGNATURE:	DATE: __/__/__

SECTION A: (May be completed by someone other than the Provider)

PATIENT INFORMATION: Indicate the patient's name and telephone number. Indicate patient's date of birth (MM/DD/YY)

PROVIDER INFORMATION: Indicate the Provider's name and complete mailing address where the exam is taking place. Accurately indicate the Provider's National Provider Identification number (NPI)

SECTION B: (Cannot be completed by the home health agency. While this section may be completed by a non-Provider clinician, or a Provider employee, it must be reviewed and signed (in Section C) by the ordering Provider.)

This section is used to gather clinical information to determine whether the patient is home bound and what skilled services the patient requires.

SECTION C: (To be completed by the Physician/Practitioner)

PROVIDER SIGNATURE AND DATE: After completion and/or review by the Physician/Practitioner of Sections A and B, the physician/practitioner must sign and date the progress note in section C.