Home Care Physician Support Evaluation Form

This form is intended to support evaluation for non-medical home care services and may assist with insurance review, care coordination, or eligibility assessment.

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1. Patient Information

Patient Name:	_____
Date of Birth:	_____
Phone Number:	_____
Address:	_____

2. Relevant Diagnoses / Conditions

[ ] Dementia
[ ] Alzheimer's Disease
[ ] Parkinson's Disease
[ ] Stroke History
[ ] Mobility Impairment
[ ] Fall Risk
[ ] Arthritis
[ ] General Weakness / Deconditioning
[ ] Cognitive Impairment
[ ] Other: _____

3. Functional Assistance Needed

Patient currently requires assistance and/or supervision with the following activities:

[ ] Bathing	[ ] Dressing
[ ] Toileting	[ ] Meal Preparation
[ ] Medication Reminders	[ ] Walking / Transfers
[ ] Transportation	[ ] Housekeeping
[ ] Memory / Safety Supervision	[ ] Fall Prevention
[ ] Overnight Supervision	[ ] Companionship / Monitoring

4. Safety Concerns

[ ] History of Falls
[ ] Unsafe Living Alone
[ ] Wandering Risk
[ ] Medication Confusion
[ ] Requires Supervision for Safety
[ ] Increased Risk for Injury or Hospitalization

5. Physician Recommendation

Based on my evaluation, this patient would benefit from non-medical home care assistance to support daily functioning and safety within the home environment.

[ ] Short-Term Assistance Recommended
[ ] Long-Term Assistance Recommended
[ ] Further Evaluation Recommended

6. Physician Information & Signature

Physician Name:	_____
Practice / Facility:	_____
Phone Number:	_____
NPI (Optional):	_____
Signature:	_____
Date:	_____

Disclaimer: This form does not guarantee insurance approval or coverage. Requirements vary by payer, plan, and state regulations.