Wells Brooke
CERTIFIED HOME HEALTH CARE

Physician Plan of Care

☐ Start of Care Order ☐ Change Order Form ☐ Interim Summary Report

Name of Patient:_____ **MR#:** _____

Episode Period:_____ **Dr:**_____

Phone:_____ **Fax:**_____

The orders shown below are being forwarded for your signature to authorize a change in treatment plan. This may also be used to inform you of the patient's current status and on-going care. Please sign and return this form within two (2) days for the patient's chart.

☐ Telephone Call
☐ Physician Appointment
☐ Resumption of Care/Change in Patient's Status Post Hospitalization
☐ Recertification
☐ Discharge Order
- Reason for Discharge:_____ D/C Summary attached? ☐ Yes ☐ No

☐ Other:_____

Effective Date of Order:_____ *Please Note: This order has been read-back for verification.
(Changes may be in any of the following: diagnosis/procedures, medications, treatments, diet, activity level, prognosis and/or any additional pertinent information).

_____

_____

_____

_____

_____

☐ **Current Medication List Attached**

☐ **Change in Visit Frequency:**

☐ Nursing:_____
☐ Home Health Aide: _____
☐ MSW:_____
☐ PT:_____
☐ OT: _____
☐ SLP:_____

Physician Comments (if any)**:**

_____

_____

_____

Staff Signature:_____ **Date**:_____

Physician Signature:_____ **Date:**_____

☐ Mailed to Physician (date):_____ By:_____ ☐ Faxed to Physician (date):_____ By:_____

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White Copy-Office Yellow Copy-Patient