WellsBrooke
CERTIFIED HOME HEALTH CARE

☐ SN ☐ PT
☐ OT ☐ SLP
☐ MSW ☐ Hha

Transfer of Responsibility for Patient Care

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

Address:_____ Phone:_____

Cross Streets:_____

Contact Person:_____ Phone:_____

Dates of coverage: From:_____ To:_____

Frequency of visit(s) to be covered: _____

Specific dates to cover:_____

**Primary RN/Therapy/Hha/MSW to resume care on: _____

Physician Name:_____ Phone #:_____

Diagnosis:_____

***Relief/Nurse/Therapist/Hha assigned:_____

Date notified/acceptance of assignment:_____

☐ V/S (TPR/BP) ranges:_____

_____

☐ Present wound description (if applicable):_____

☐ Present wound treatment:_____

Teachings/Interventions/Instructions:_____

_____

_____

LABS:_____

Other:_____

Disciplines: SN:_____ Sup. Visit Due Date:_____

PT:_____ OT:_____ SLP:_____

MSW:_____ Hha:_____

Plan of Care (485) attached:	☐Yes	☐No	
DNR order:	☐Yes	☐No	
Therapy Eval. and Care Plan attached:	☐Yes	☐No	☐N/A
Any change in medication(s) from Form 485:	☐Yes	☐No	
- If yes, current or updated medication list attached:	☐Yes	☐No	

Remarks:_____

_____

Signature:_____ **Date:**_____

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White Copy-Office Yellow Copy-Patient