PHYSICIAN'S ORDERS FOR HOME HEALTH CARE

FROM:_____ Date:___/___/___ TO:_____

PHONE:_____ Time: _____ PHONE: (239) 427-4480

FAX: _____ FAX: (239) 376-0660

PERSONAL SERVICE CARE LLC

Physician's Name		**Phone**	
Patient Name		**DOB**	
Address			
Fee Source	❑ Medicare ❑ Private Insurance ❑ Medicaid ❑ Self pay		
Admit Date		**Discharge Date**	
DIAGNOSIS			
Allergies			
Services Required	❑ Skilled Nursing ❑ Physical Therapy ❑Occupational Therapy ❑ Respiratory Therapist ❑ Medical Social Worker ❑ Speech Therapy ❑ Home Health Aide ❑ OTHER:		
Any Specific Orders			
Home Going Medications			

I ❑ **Certify** I ❑ **Recertify**
that the above patient is under my care and requires the above Home Health Services, because they are confined to home. These professional services are to be provided on an intermittent basis and the established plan will be reviewed by me at least every two months. These services are related to the diagnosis stated above.

Physician's Name: (Print)			
Attending Physician (Signature):			
Date:		**Time**:	