



RECERTIFICATION ORDER/TEAM CONFERENCE

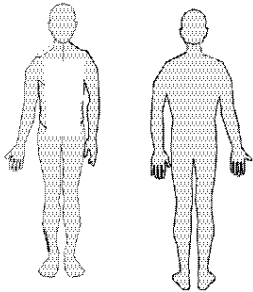
Last Name	First Name	Physician	MR#
Date of order	Recertify Patient	From:	To:
Reason/DX:			
Disciplines ordered:			
SN:		PT:	
AIDE:		Other:	
Date last seen by MD:			
Specific orders and medications changes:			
Summary of Patient Status:			
Signature of RN Receiving:		Date:	
Signature of Physician:		Date:	
PLEASE SIGN AND FAX TO (305)629-9236 AND RETURN ORIGINAL TO 8875 NW 23 St. Unit A, Miami, FL 33172 WITHIN 7 DAYS. THANK YOU			

RECERTIFICATION ORDER

Patient Name _____ Med. Record _____
 SOC: _____ Recertification period: _____ to _____
 Primary Diagnosis _____ Onset Date _____
 Secondary diagnoses _____

What negative findings substantiate this Patient to be recertified?

Wound/decubitus/ulcer orders:



Foley Yes No Size _____ FR _____ CC Change Q _____ Date last changed _____
 Problem: _____
 Mental Status: _____ Activity: _____
 Functional limitations/homebound status: _____

Diet: _____ Need for Home Health Aide: _____

Who does patient live with? _____ Caregiver _____
 Overwhelmed with _____ Patient's care _____ Household duties. Medical Supplies _____
 Verbal order written during this certification: _____

Start Date	MEDICATION (changes, addition, deletions)	Dose	Route	Frequency	Duration	D/C Date

Services that need to continue (Frequency):
 SN _____ PT _____
 HHA _____ ST _____
 MSW _____ OT _____

Discharge Plans _____

MD Name/ Phone _____

Last MD visits _____ Last MD contact by nurse _____

RN _____ Date _____

Physician Signature: _____ Date: _____

SALUD HOME CARE

PHYSICIAN ORDER:

- INITIAL/ADMISSION ORDER
RECERTIFICATION ORDER
REINSTATEMENT ORDER
DISCHARGE ORDER
MODIFY/VERBAL ORDER

Order Date: _____

Sent/Faxed on: _____

Patient's Name: _____ Med. Record #: _____

SOC Date: _____ Cert. Period: _____ D/C Date: _____

Diagnosis: _____

Disciplines ordered/frequency: SN HHA PT OT ST MSW Other:

ORDERS/FREQUENCY/DURATION Nursing / Aide (Locator 21)

- N/A Observation/Assessment complete system, vital signs, complications:
Assess patient's response to new/changed meds and/or treatment/procedures
Teach new/changed medication regimen, side effects
Wound Care order:

Diabetes Management Insulin Dependent Non Insulin Dependent

Order: _____

- Report significant finding, monitoring: BP BS Anticoagulant Therapy Emergency Plan
Teaching/monitoring Nutritional Status, Hydration, Diet: Safety Precautions
Other: _____

Medication Management: See Medication Scheduled New Meds: _____

Aide to Assist with ADL's, Personal Care Personal Hygiene Other: _____

ORDERS/FREQUENCY/DURATION Therapy (Locator 21)

- N/A PT ST OT evaluation (circle) Therapeutic exercises Balance/Coordination tech
Gait training/evaluation Assistive Device training Safety awareness/training
Pain Management/Control/Treatment Active ROM exercise Massage EMS
Transfer Mobility from to Home Exercise Program Other: _____

PT: _____

OT: _____

ST: _____

ORDERS/FREQUENCY/DURATION MSW (Locator 21)

- N/A Evaluation/Assess home situation Referral to Community Assess social/emotional factors
Financial Resources information ALF/Hospice/Nursing Home placement/referral
Other: _____

Clinical findings support the need for the above services: _____

Order verified/read-back by (Name/Signature/Title): _____

Date: _____

Physician Name: _____ Address: _____

Phone: _____

UPIN #: _____

MD Signature: _____ Date: _____