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)

☐ Observation/Assessment complete system, vital signs, complications: _____
☐ Assess patient's response to new/changed meds and/or treatment/procedures ☐ Fall precautions/prevention
☐ Teach new/changed medication regimen, side effects ☐ Pain assessment/management/treatment
☐ 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: _____

EXPRESS SERVICES OF MIAMI, INC.

VERBAL/MODIFY ORDER FORM

Patient _____ To Dr. _____
SOC: _____ _____
Med. Record: _____ _____
Date order given _____ Effective Date: _____

ANY CHANGES, ADDITIONS OR DELETIONS FROM INITIAL PLAN OF CARE/RECERT:
(INCLUDE DISCIPLINE FREQUENCIES TREATMENTS AND SUPPLIES NEEDED)

_____
_____
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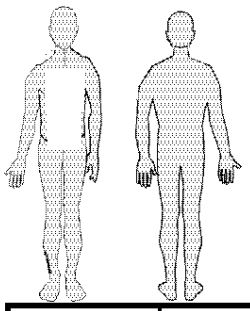

Wound/decubitus/ulcer orders:

_____
_____
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_____

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

SIGNATURE/Title of Person Accepting Orders: _____ Date: _____

I CONFIRM ISSUANCE OF THE ABOVE VERBAL ORDERS _____
Physician Signature & Date

Please mail to: Express Services of Miami, Inc., 6955 NW 77 Ave. Suite 307. Miami, Fl 33166

Dade-Kendall Home Healthcare Services, Inc.

MODIFICATION ORDER

DATE OF ORDER: _____
DATE EFFECTIVE: _____

PATIENT NAME: _____
MR#: _____

PHYSICIAN NAME: _____
ADDRESS: _____
PHONE: _____ **FAX:** _____

REASON FOR MODIFICATION ORDER:

_____
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ORDERS:

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_____ _____
PHYSICIAN SIGNATURE **DATE**

_____ _____
CASE MANAGER SIGNATURE **DATE**

HOME HEALTH CARE INC

7175 SW 8 Street.
Suite 213
Miami, Fl 33144

Ph: (305) 265-1886
Fax: (305) 265-2106
email: fande@fandehomehealthcare.com

MODIFY ORDER FORM

Physician Name: _____

Address: _____

_____

_____

Patient: _____ MR: _____ HIC#: _____

SN _____ PT _____ ST _____ OT _____ RT _____ HHA _____

Dx: _____

_____

Reason: _____

_____

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Orders: _____

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Date or Order	DOCTOR PLEASE SIGN, DATE & RETURN WITHIN DAYS
RN	Physician Signature Date

GENTLE HANDS
HEALTH CARE SERVICES
Lic # HHA20400096

6840 SW 40 St. Suite 21
Miami, FL 33155
Ph: (305) 663-0886 Fax: (305) 663-1393

MODIFIED ORDER

Physician's Name: _____

Address: _____

_____

Client's Name: _____ MR#: _____ HIC#: _____

Diagnosis(es): _____

_____

Reason: _____

Orders: _____

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Other changes to current POC at this time? Yes _____ No _____

Order obtained by: _____

Order read back & verified by: _____

Client informed? _____ Yes _____ No

Mod. Order #: _____

Happy Heart Home Health Care, Inc
14750 NW 77 Ct. Suite 304
Miami Lakes, FL 33016
Ph: (305) 362-4585

Physician Modified Order

Order ID: _____ Patient Name: _____
Patient ID: _____

Physician: _____
Address: _____ Received by: _____
_____

Phone: _____ SOC Date: _____
Fax: _____ Order Date: _____

Orders

Nurse's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Order read back to _____ Date: _____
and verified by: (Name/Title of Authorized Individual)

Masu System Group, Inc.

MODIFIED ORDERS

Date: _____
Physician's Name: _____
Address: _____
_____

Dear Dr.: _____

These are additional orders and/or changes of orders on your client as per your instructions.
Please return to us in the enclosed stamped self-addressed envelope the verified signed orders.

_____ _____
Client Name Client MR Number

Additional Diagnosis(es): _____
_____
_____
_____

Additional/Change of Service/Frequency: _____
_____
_____
_____

Additional Medical Supplies Ordered: _____
_____
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_____

Client Informed? _____ Yes _____ No

_____ RN

Please Sign and Return.
Thank You,

Physician's Name: _____ Date: _____

14750 NW 77th Ct. Suite 108 Miami Lakes, FL 33016
Phone (305) 817-1800 Fax: (305) 817-8622

MODIFICATION ORDER

PATIENT NAME: _____ MR NUMBER: _____

DATE OF ORDER: _____ EFFECTIVE DATE: _____

PHYSICIAN NAME: _____ PHONE: _____

ADDRESS: _____
_____ FAX: _____
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ORDERS: _____
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_____ _____
NURSE SIGNATURE DATE

_____ _____
PHYSICIAN SIGNATURE DATE

ALONDRA HOME HELP, LLC.

INITIAL PHYSICIAN'S ORDERS

Verbal/Telephone/Faxed

Date Ordered: _____

Patient Name, Address, Phone:

_____

Last Name First Name Middle Initial

_____

Address City Zip Code Phone #

Emergency Contact Name & Phone #: _____

Eligibility: □Yes □No Date of Eligibility: _____

Physician:			
Last Name	First Name	Mdle Initial	UPIN #
Address	City	Zip Code	Phone #

Name of Caller: _____

Discipline: □RN □HHA □PT □OT □ST □MSW □Other: _____

Diagnosis/Explanation	Verbal Order/Frequency
Medications	
DME:	

Physician's Signature: _____

Professional Signature (RN/PT): _____

State regulates that a Plan of Treatment (POT) must be signed within 30 days of date of verbal orders.