Miracle Blessed Care Enterprise, Inc.

RECERTIFICATION ORDER-EVALUATION/AGREEMENT UPDATE

(Recert evaluation must be completed within 5 days before ending episode) ***(Certifying Physician Statement)***

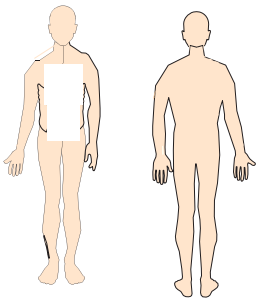
Patient Name _____ **Med. Record** _____
SOC: _____ **Recertification period:** _____ **to** _____
Primary Diagnosis _____ **Onset Date** _____
Secondary diagnoses _____ _____
_____ _____
_____ _____

What negative findings substantiate this Patient to be recertified? (Continuing Need for Services Statement)

_____
_____
_____
_____

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/Charges): ☐ **Medicare payer, no charges expected** ☐ **Charges changes below**
☐ **Agency regular charges explained in de Information Handbook**
SN _____ **PT** _____
HHA _____ **ST** _____
MSW _____ **OT** _____

Discharge Plans _____
_____

Physician Recertification Statement: I certify that in my estimation continued services will be required for _____.

MD Name/ Phone _____ **Last MD visit** _____ **Last MD contact by nurse/therapist** _____

Patient/Representative Signature: _____ Date: _____

RN/Therapist Name/Signature/Title_____ **Date** _____

Physician Signature: _____ Date: _____

Original (Patient Chart) *Copy (Physician)*