

BETHHAROLD HOME CARE

Office: (248) 423-3300 Fax: 423-3301

CONTINUING PLAN OF CARE

Last Name:	First Name:	To:
Address of Care:		From:
Patient's Address (if not same as above) Patient's Phone #		Referral Date: Reported By: Date 1 st Visit: Reported To:
Complete Date of Birth: Sex: Male Female Marital Status: S M W D Sep.		Hospital for Drugs or Supplies:
Responsible Relative or Friend: Relationship: Phone # ()		Medicare No: Medicaid No: BCBS No: Name of Subscriber:
Hospital Case No: Admission:	Room No: Discharge	Other Insurance: Policy No. & Subscriber:

I. REPORTED BY PHYSICIAN

Diagnosis: (List Primary first & Date of Onset)	Prognosis: Good Fair Guarded Poor
Surgery Performed and Date(s):	Patient informed of Diagnosis: Yes No
Complications	Family informed of Diagnosis: Yes No
Rehabilitation Goal(s):	Brief Medical History:
	Visit to MD: Office Clinic Date:

II. MEDICAL ORDERS AND PLAN OF TREATMENT

Diet: Activity: Services Requested: Skilled Nursing Social Worker (MSW) Physical Therapy Speech Therapist Occupational Therapy Home Health Aids <hr/> Durable Medical Equipment Need: Ordered From: (Company & Phone No)	Medications:
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Treatment/Teaching/Exercise Program: Assess and evaluate patient status. Teach disease process, medication action & S/E emergency plan. Report any instabilities to the program.

I certify that the above patient is under my care, requires the above Home Health Service, and is confined to his 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 & conditions for which he/she received treatment while recently hospitalized.

Date:	Physician's Signature/Address/Phone No:
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