New Century Home Health Care, Inc.
1387 E. 12 Mile Road, Madison Heights, MI 48071
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Continuing Patient Care/Medical Verbal Order MR No.

CLIENT NAME: (Last) (First)	Community Liaison: Referral Source: ☐ MD's Office ☐ Hospital ☐ Rehab/SNF ☐ Other:
Home Address: Street: Apt. No. City State ZIP Code Tel. No.	Verbal SOC: Reported By: SOC Date: Reported To:
Address For Care: ☐ Check Box If The Same As Home Address Tel. No.	Medicare No. Medicaid No. Private Insurance: Name Of Subscriber: Policy Number: Group No.
DOB: SEX: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Separated	Name of Alternate Contact: Phone No. Relationship To Patient:
DIAGNOSES: (List Primary Diagnosis First) 1) _____ ☐ Onset ☐ Exac 2) _____ ☐ Onset ☐ Exac 3) _____ ☐ Onset ☐ Exac 4) _____ ☐ Onset ☐ Exac 5) _____ ☐ Onset ☐ Exac	PROGNOSIS: ☐ Good ☐ Fair ☐ Guarded ☐ Poor MEDICATIONS: Dosage Freq. Route Check Current Meds @ Home

DIET:	ALLERGIES:	ACTIVITIES PERMITTED:	DME/SUPPLIES:	FUNCTIONAL LIMITATION

PHYSICIAN ORDER

Service Ordered	☐ SN	☐ PT	☐ OT	☐ SP	☐ MSW	☐ HHA	Other

VERBAL ORDERS/HOME HEALTH PLAN:

SN- Skilled Assess./Observe
- ☐ V.S. (TPR/BP)
- ☐ Blood Sugar
- ☐ CVR Status
- ☐ Metabolic Status
- ☐ Nutritional/hydration Status
- ☐ Wound Status/Integumentary
- ☐ Medication Response
- ☐ Disease Progression
- ☐ S/S Complications./Infection
- ☐ Pain Level & Management

Teach:
- ☐ Diabetic Care
- ☐ Glucometer Testing
- ☐ Disease Processes/Mgt.
- ☐ Med. Effect/Side Effect
- ☐ ER Plan/Safety Measures
- ☐ Diet/Fluid Req./Restrictions
- ☐ S/S of Complications/Infection
- ☐ Med. Schedule/Compliance
- ☐ Foley Cath./TF/Wound Care Management
- ☐ Care of Bedbound

Provided Direct Care:
- ☐ Admin. IV Therapy
- ☐ Insertion of Indwelling Cath.
- ☐ Wound Care
- ☐ Colostomy Care Mgt.

PT _____
OT _____
SP _____
AI _____
MSW _____
OTHERS _____

Other Orders:

Verbal Order Received by: **Title** **Signature** **Date**

Face-To-Face Certification

Date Of Face-To-Face Encounter With Patient:	**Reasons For Homebound Status:**

I certify that this patient is under my care and that I or a nurse practitioner or a physician's assistant working with me, had a face-to-face encounter with the patient as requirement for home care admission as prescribed by Medicare. I further certify that based on my clinical findings, above patient is homebound and confined to his/her home due to his/her current condition. These professional services are to be provided on an intermittent basis and the established plan will be reviewed by me, at least every 60 days. These services are related to the diagnoses stated above and reasons & conditions for which he/she received treatment.

Physician's Printed Name: Physician's Signature: Date	Address: Phone No. Fax No.

Submit