Rehabilitation One Home Health, LLC.

2234 Ford Rd Dearborn Hts, MI 48127
Phone (313)565-2224 Fax (313)565-2257

Patient Last Name: Fist Name:	SSN:
Address of Care:	From Doctor:
Patient's Address (if different than above)	Referral date: Reported by:
Phone :	Hospital for drugs or supplies:
Date of birth: Sex: ( ) male ( ) female Marital status: S M W D Sep	Medicare #:
Emergency contact person: Relationship: phone:	Other insurance: Policy #

Report by physician:

Diagnosis: (list primary first and last date of Onset)	Prognosis: Good Fair Guarded Poor Patient informed of Diagnosis: Yes No Family informed of Diagnosis: Yes No Brief Medical History: Visit to MD: ( ) office ( ) clinic Date:

Medical orders and plan of treatment:

Diet: Activity: Skilled services: □ Skilled nursing □ Social Worker (MSW) □ Physical therapy □ Home Health aide □ Occupational therapy	Medications: Allergies:
Durable medical equipment needed:	Ordered from : (name and phone #)

Staff signature: _____ Date: _____

Treatment /Teaching/Exercise Program: Assets and evaluate patient status. Teach disease process, medication action &S/E and emergency plan. Report any instability to the Physician.
I certify that the above patient is under my care, requires the above Home Health Service, and is confined to his/her home. 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 diagnosis stated above and

conditions for which he /she received treatment while hospitalized.

_____ _____

Physician's Signature Date Address and phone number

These orders have been "Read Back" for verification of content.