

Physician Orders

Patient Information	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Referrals 916-485-8200 ext. 122
		FAX 916-485-4400
Patient Name	Date of Birth	Patient's Phone
Address	City	ST
	Zip	Social Security Number
Insurance Info:	<input type="checkbox"/> MediCare	<input type="checkbox"/> Medi-Cal
	<input type="checkbox"/> Other	ID#
Emergency Contact:	Contact Phone:	

Diagnosis:		
Home Health Orders <input type="checkbox"/> Skilled Nursing	Check Disciplines Required <input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy
Frequency: Skilled Observation: <input type="checkbox"/> Medication <input type="checkbox"/> Pain <input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetic <input type="checkbox"/> Respiratory <input type="checkbox"/> Wound: _____ _____ <input type="checkbox"/> Labs: _____ _____ <input type="checkbox"/> Other: _____ _____	Frequency: Evaluate and instruct for: <input type="checkbox"/> Ambulation/Gait <input type="checkbox"/> Balance <input type="checkbox"/> Transfers <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Wheelchair Mobility <input type="checkbox"/> Safety/Fall Risk <input type="checkbox"/> Range of Motion <input type="checkbox"/> Weakness/Strengthening <input type="checkbox"/> Other:	Frequency: Evaluate and instruct for: <input type="checkbox"/> Swallowing <input type="checkbox"/> Voice Intelligibility <input type="checkbox"/> Hearing <input type="checkbox"/> Language Processing <input type="checkbox"/> Cognition <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Personal Care <input type="checkbox"/> Assist w/ROM
NOTE	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Medical Social Worker Evaluate and instruct for: <input type="checkbox"/> Family Support System <input type="checkbox"/> Counseling Referrals <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> UnSafe Environment <input type="checkbox"/> Stress/Coping/Grief <input type="checkbox"/> Alternate Living <input type="checkbox"/> In-Home Assistance <input type="checkbox"/> Other
In order to receive Occupational Therapy or Medical Social Worker, you MUST have either Skilled Nursing, Physical Therapy, or Speech Therapy on the case.	Frequency: Evaluate and instruct for: <input type="checkbox"/> ADLs <input type="checkbox"/> Energy Conservation <input type="checkbox"/> Sensory Dysfunction <input type="checkbox"/> Orthotics <input type="checkbox"/> Equipment and Adaptive Devices <input type="checkbox"/> Other	

Comments: _____

Physician Signature OR verbal orders by: _____

Date _____

Print Name of Person Signing order _____

Phone # _____

Fax # _____