True Harmony Home Health
Our Priority is Your Care

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PHYSICIAN ORDERS

AGENCY NAME: TRUE HARMONY HOME HEALTH, LLC

AGENCY ADDRESS: 700 Central Expressway South; Ste 400 | Allen TX-75013

Patient Name: ____________________________________ Medicare #______________________

Address: ______________________________________CITY:____________ ST: ___ ZIP: _______

Home Phone: _________________ Cell Phone: ___________________DOB: ______________

TELEPHONE/ADDITIONAL OR CHANGE OF ORDERS ON YOUR PATIENT

Date: __________________________________ **Time:** _______________________________

Patient Problem/Diagnosis:

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Intervention/Order:

☐ **Admit** patient to **True Harmony Home Health** for Home Health Care Services:

Patient requires ☐ **SN (Skilled Nursing)**

☐ **PT (Physical Therapy)**

☐ **OT (Occupational Therapy)**

☐ **ST (Speech Therapy)**

☐ **Recertify** patient to **True Harmony Home Health** for Health Care services for a period of 60 days. SN to monitor, re-evaluate & manage patient's medical regimen.

☐ **Discharge** patient from home health services due to:

☐ Patient/Physician Request
☐ Patient moved from service area
☐ All goals have been met
☐ Patient moved to Acute Facility
☐ Patient is non-compliant
☐ Patient Opted for HMO

Goals: To meet patient's medical needs.

Patient Informed: ☐ Yes ☐ No

Physician Signature ____ Date ______________

** **Doctor, please sign this form immediately and return it. Thank you****