

CONTINUING PATIENT CARE FORM

Patient	Last Name	First Name	To: Experts In Home Health Management, Inc. 19148 East 10 Mile Road, Eastpointe, MI 48021-1449 Tel: (800) Home Care (466-3227) Fax (586) 585-0209
Address for Care		City or Twp.	FROM: Hospital, Clinic, E.C.F. & Address
Phone			
Patient's Address, if not same as above		Phone	Referral Date Agency 1st Visit Date
			Reported by: Reported to:
Complete Birth Date	Sex M F	Marital Status S M W D Sep	Hospital for Drugs or Services
Responsible Relative or Friend			Medicare No.
Relationship			Medicaid No.
Phone			
Hospital Care No.	Room No.	Admission Discharge	Blue Cross No.
			Other Ins: (Give Name)

II. REPORT BY PHYSICIAN

Diagnoses: List Primary First and Date of Onset

Prognosis Good Fair Guarded Poor
 Patient Informed of Diagnosis Yes No
 Family Informed of Diagnosis Yes No

Surgery Performed (*Type and Date*)

Brief Medical History

Complications:

Rehabilitaion or Treatment Goal:

Date and Place of Physician's Next Visit:

Home Office Clinic E.C.F.

MEDICAL ORDERS AND PLAN OF TREATMENT

Minimum Number of
Hosp. Days Saved

Diet (*Specify*)

Dressings or Treatment (*Specify*)

Catheter Size _____ Frequency of Change _____ Irrigation Solution _____ Amount _____ Frequency _____

Enema (*Specify*)

Medications:

Specify Therapeutic Exercise Program

Activity Allowance:

Patient Uses: Prostheses Brace Walker Wheelchair Cane Other _____

Physical Therapy Occupational Therapy Social Service Speech Evaluate Need for Home Health Aide
 Teaching Patient or Family

I certify that the above patient is under my care and requires the above Home Health Services because he is confined to his home. These professional services are to be provided on an intermittent basis and the established plan contained in the record will be reviewed by me at least every two months. These services are needed to treat all of the conditions for which the patient was treated during the related in-patient hospital or post-hospital extended care facility approved stay.

Date	Physician's Signature	Address	Phone	Signed by Resident
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III. HOSPITAL NURSE'S ASSESSMENT: Reason For Referral?

Activity Limitations:

- Ambulatory
- Ambulatory with assistance
- Confined to Bed Chair

Activities of Daily Living:

- Independent
- Needs Assistance
- Unable to do

Vital Signs with Ranges

- TPR
- BP
- WT

Mental State:

- Alert
- Apathetic
- Confused
- Depressed
- Disoriented
- Other _____

Incontinence:

- Bowel
- Bladder
- None
- Partial
- Complete

X-Ray: Findings & Dates

Disabilities and Impairments:

- Mentality
- Speech
- Hearing
- Vision
- Sensation
- Amputation
- Paralysis
- Contractures
- Decubiti

In-Hospital Teaching:

- Bowel Training _____
- Bladder Training _____
- Colostomy Care _____
- Insulin Administration _____
- Modified Diet Instruction
- Copy of Diet to Patient
- Copy of Diet to Agency
- Other _____

Laboratory: Findings &

- Hb.
- B.S.
- BUN
- Culture
- Serology

Allergies:

Other Significant Findings:

Special Problems and Other Narrative:

Diagram to Show Location, Size, Extent, etc, of Wound, Stoma, Burn, Decubiti, Graft or Other Affected Area.

Signature _____ Title _____

IV. REPORT OF SPECIAL HOSPITAL SERVICES: Dietitian, Physical Therapist, Social Worker, etc.

Signature _____ Title _____