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. Phone	FROM: Hospital, Clinic, E.C.F. & Address
Patient's Address, if not same as above Phone	Referral Date Reported by: Agency 1st Visit Reported to: Date
Complete Birth Date Sex Marital Status M F S M W D Sep	Hospital for Drugs or Services
Responsible Relative or Friend	Medicare No.
Relationship Phone	Medicaid No.
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

Surgery Performed *(Type and Date)*

Complications:

Rehabilitaion or Treatment Goal:

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

Brief Medical History

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

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 ☐ Depressed ☐
- Apathetic ☐ Disoriented ☐
- Confused ☐ Other _____

Incontinence:

	None	Partial	Complete
Bowel	☐	☐	☐
Bladder	☐	☐	☐

X-Ray: Findings & Dates

Disabilities and Impairments:
- Mentality ☐ Amputation ☐
- Speech ☐ Paralysis ☐
- Hearing ☐ Contractures ☐
- Vision ☐ Decubiti ☐
- Sensation ☐

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 _____