30600 Telegraph Rd. Suite 2226
Bingham Farms, MI 48025
Tel: 248-540-8980 Fax: 248-540-8982
Toll: 888-611-6633 Email:athome2226@yahoo.com

At Home Network, Inc.

Medicare, BC/BS, Medicaid
Certified Home Health Care Agency

CONTINUING PLAN OF CARE

LAST NAME:_____ FIRST NAME:_____

Address of Care: _____
_____
Tel: _____
SS#: _____
DOB: _____
Sex: Male Female
Marital Status: S M W D Sep.

Referring Physician:_____
Address: _____
_____
Tel: _____ Fax: _____
UPIN: _____NPI:_____
Referral Date: _____
Hospital Admit & Discharge Date:_____

Emergency Contact:
Relationship:
Tel: _____

Primary Care Physician: _____
Address:_____
Tel: _____ Fax: _____

Primary Diagnosis:

Secondary Diagnosis:

Medicare: _____
Medicaid: _____
BCBS: _____Group: _____
Other: _____

Medications / Special Instructions/Home Bound Status:

II. MEDICAL ORDERS AND PLAN OF TREATMENT

Services Requested:

Skilled Nursing	Social Worker (MSW)
Physical Therapy	Speech Therapist
Occupational Therapy	Home Health Aide
Dietician	Psych Nurse
Anodyne Therapy	Wound Vac
Evaluate for Homecare	Wound Care Nursing

Notify Physician for:

BP<_____or>_____ BS<_____or>_____

PR<_____or>_____ RR<_____or>_____

Temp<_____or>_____ Weight gain >2lbs in 24 hr or less

Medical Equipment Needed:

Lymphodema Pump	Test Strips & Lancets
Manual Wheel Chair **"need H&W"**	Glucose Monitor
Electric Wheel Chair	Diabetic Shoes
Walker with wheels	TENS Unit
CPAP **" need sleep study"**	Walker
Hospital Bed **"need H&W"**	Air Mattress
Oxygen **"need SAT level"**	Cane
Nebulizer	Back or Knee Brace (circle)

****PLEASE FAX A RX SCRIPT FOR EQIUPMENT or SUPPLIES NEEDED****

Specify Other Equipment Needed Here

Height: **Weight:**

Physician's Signature: _____ **Date:** _____

Clinical RN Signature: _____