Prolink Home Health Corporation
8500 N. Stemmons Frwy. Suite 3000 DALLAS TX 75247-
Ph: (214) 267 1985 Fax: (214) 267 1983

Date **01/02/2013** Time **01:13 PM** Patient Name **ADAMS, BETTY**

Physician Name **KETHA, SUMANA** Medical Record Number **ADB3319** DOB **10/30/1939**

Dear Doctor:
These are Additional Orders and/or change of orders on your patient. Please sign and return in the enclosed stamped, self addressed envelope. This order serves as a modification to the patient's plan of care.

Problem(s) And/or Additional Diagnosis(es)

Frequency/Duration and Treatment Orders/Interventions/Medications
RECERTIFY PATIENT FOR THE EPISODE OF 01/04/2013- 03/04/2013.SN FREQUENCY 1W8 BEGINNING WEEK TWO TO ASSESS, INSTRUCT AND EVALUATE PATIENT ON DISEASE PROCESS, MEDICATION ADMINISTRATION, DIET REGIMEN AND SAFETY MEASURES.

Change in Goals: ☐ Yes ☒ No If yes, specify:

Additional Medical Supplies Ordered

Patient Informed: ☒ Yes ☐ No

Informed: ☒RN ☒ LVN ☐ PT ☐ OT ☐ SLP ☐ HCA ☐ MSW ☐ RD ☐ PCC ☒ Care Giver ☒ Supervisor
☐ Other: Please specify

Change in Schedule: ☐ Yes ☒ No

☐ Vital Sign Out of Range MD notified.

Copy of this order also sent to:

☐ Check if post hospitalization re-assessment. Hospital dates: To

Please sign, date and return. Respectfully,

Signature (LVN) Date
Signature (RN Case Manager) ✔ Digitally Signed By JOSEPHINE CHIDI, RN. Date 01/02/2013
Physician's Signature Date

Physician: Dr. Ketha, Sumana
Signature: S. Ketha M.D
Date: 1/22/2013

Clinician: Chidi, Josephine
Signature: J. Chidi RN
Date: 1/2/2013