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

Date **01/16/2013** Time **03:15 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)

PLEASE DISCHARGE PATIENT FROM ALL HOME HEALTH SERVICES. GOALS MET.

Frequency/Duration and Treatment Orders/Interventions/Medications

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

GOALS MET

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 01/16/2013

Physician's Signature _____ Date _____

Physician: Dr. Ketha, Sumana

Signature: S. Ketha M.D

Date: 3/8/2013

Clinician: Chidi, Josephine

Signature: J. Chidi RN

Date: 1/16/2013