EMRICK SERVICES INC
2301 Forest Lane Suite 400, Garland, TX. 75042 Tel.972-494-5444 Fax.972-494-2331

Re-Cert Order

Physician Name:	KETHA SUMANA , MD	**Address:**	2925 Skyway Cir N Ste. B
Tel:	972-675-7313		
Fax:	972-675-7310		Irving TX 75038

Nurse or Therapist's Signature:	**Date of this Document:**
Thomas-Stahle Nancy Ann, RN	07/08/2016

Patient's Name: Woodard Garland **Patient Number:** EMH418

Episode: 07/14/2016 to 09/11/2016

Orders:

Re-Certify for Home Health Care Services
Re-Certify to **EMRICK SERVICES INC**
I certify/recertify that this patient is confined to his/her home and needs one or more of the following:

☐ Skilled Nursing Care ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Medical Social Work ☐ Home Health Aide

The patient has had a face to face encounter by me and is under my care. I have authorized the services on this plan of care and will periodically review the plan

Additional Orders:

I estimate continued services will be required for:
_____

SN to perform skilled assessment, skilled observation, teaching of disease process, diet and medication, procedure and evaluation of treatment.
(X) SN Frequency: 1W9
( ) HHA Frequency: _____
( ) PT: to evaluate and establish goals.
( ) MSW: for socio-economic evaluation.
( ) for other:_____
( ) OT: to evaluate and establish goals.
( ) SP: to evaluate and establish goals.

PLEASE SIGN AND RETURN TO OUR OFFICE WITHIN 48 HOURS. THANK YOU

_____ _____
Physician's Signature Date

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Physician: Dr. Ketha, Sumana

Signature: S.Ketha M.D

Date: 8/12/2016

Clinician: Thomas-Stahle, Nancy A.

Signature:

Date: 7/13/2016