

Date 10/31/2012 Time 04:01 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 as per your instructions. 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 11/05/2012- 01/03/2013.SN FREQUENCY 1W9 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 ☐ HHA ☐ MSW ☐ RD ☐ PCC ☒ Care Giver ☒ Supervisor
☐ Other: Please specify

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	10/31/2012
Physician's Signature	_____	Date	_____

Physician: Dr. Ketha, Sumana

Signature: 

Date: 12/13/2012

Clinician: Chidi, Josephine

Signature: 

Date: 10/31/2012