Central Healthcare, Inc.

PHYSICIAN'S ORDER

Patient's Name: _____ D.O.B. _____

Address: _____

Phone: _____ Medicare #: _____

Physician' Name: _____ NPI #: _____

Address: _____

Phone: _____ Fax: _____

Prescription Order:

[ ] Please admit to **Central Healthcare, Inc**. Date: _____

[ ] Please recertify for continued services. Date: _____

[ ] Please send skilled nurse for:

-Skilled observation and assessment of physiologic functional, behavior and nutritional status

-Skilled observation and assessment on safety precautions

-Evaluate patient's response and compliance to plan of care

-Report to physicians any significant findings

-Perform lab exams as per request of physician.

- Visit Frequency: _____

[ ] Please send physical therapist for evaluation and management.

-To increase muscle strength and mobility

[ ] Other services: _____

Physician's Signature: _____ Date: _____