VICTORY HOME CARE, INC

14999 TELEGRAPH ROAD. Michigan 48239 Tel: (313)535-3500 Fax (313) 766-4080

Continuing Plan of Care

Patient Name:	To: VICTORY HOME CARE, INC
Address of Care:	From:
Patient's Phone:	Referral Date: Given by: Requested SOC date: Taken by:
D.O.B. S.S.# Sex: ( ) Male ( ) Female Marital Status: S M W D Contact Person: Relationship: Phone:	Hospital: Pharmacy: Medicare # Medicaid # BCBS Subscriber:
Hospital/SNF Admit Date:	Hospital/SNF D/C Date:

Reported by Physician

Primary Dx: Secondary Dx: Surgery Dx: Other Dx: Onset/Exacerbation date:	Prognosis: Good Fair Guarded Poor Past Medical Hx: Last MD Visit

Medical Orders and Plan of Treatment

Diet: Activity Permitted: Services Requested: ( ) *RN ( ) *PT ( ) *OT ( ) *ST ( ) *MSW ( ) *HHA	Medications: Lab Work: Supplies/DME:
Assess & Eval patient status Teach disease process & meds Wound Care Orders ______________________ ____ Other: __________________________________	I certify that the above patient is under my care, requires the above home health service, and is homebound. These professional services are to be provided on an intermittent basis and the established plan will be reviewed by me at least q 2 months. These services are related to the diagnosis stated above and conditions for which he/she received treatment while recently in hospital or office/clinic.

Physician's Name:______________________________ Phone:___________________ Fax:_________________

Address: ____NPI________________

Physician's Signature: Date: