



24333 Southfield Rd., Ste. 200  
 Southfield, MI 48075  
 800.430.0309 / Fax: 248.569.2148

# CONTINUING PLAN OF CARE

<b>Patient Name: (Last, First, Middle Initial )</b>		<b>To Agency:</b> Focus Care Home Health 24333 Southfield Rd. Ste. 200 Southfield, MI 48075 Tel: 800.430.0309 / Fax: 248.569.2148	
Address for Care:  Tel: (        )		From:	
Patient's Address (If not the same as above)  Tel: (        )		Referral Date: / /	Reported By:
		Date of First Visit: / /	Reported To:
Complete Date of Birth:  Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		Hospital for Drugs and Supplies:	
Responsible Relative or Friend:		<b>INSURANCE</b>	<b>Medicare No.</b>
Relationship:                      Tel: (        )			<b>Medicaid No.</b>
Hospital Case No:                      Room No.			<b>PPOM:</b>
			<b>Name of Subscriber:</b>
Admission:                                      Discharge: / /                                      / /			<b>Other Insurance:</b>
			<b>Policy No. and Subscriber</b>

## REPORTED BY PHYSICIAN

<b>Diagnosis: (List primary first and date of onset)</b>  Surgery Performed and Date(s):  Complications:  Rehabilitation Goal(s):	<b>Prognosis:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Guarded <input type="checkbox"/> Poor  Patient Informed of Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Informed of Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No  Brief Medical History:   Visit to MD: <input type="checkbox"/> Office <input type="checkbox"/> Clinic      Date: / /
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## MEDICAL ORDERS AND PLAN OF TREATMENT

Diet:  Activity:  <b>Services Requested:</b> <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Social Worker <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> HHAide  Durable Equipment Needed: Ordered From (Company and Tel. No.):	<b>Medications:</b> PLS CHECK MEDS./ORDER @ HOME    Lab Draws:
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I certify that the above patient is under my care, requires that the above Home Health Services, and is confined to his home. These professional services are to be provided on an intermittent basis and I will review the established plan at least every two months. These services are related to the diagnosis stated above and conditions for which he/she received treatment while recently hospitalized.

Physician's Signature:	Address:	Tel:
UPIN No:		
License No:		Date: / /