## COUNTY HOSPITAL HOME HEALTH

**Patient's Name:** ____________  
**Physician's Name:** ____________  
**Order Date:** ____________  
**Effective Date:** ____________

### Signature of Nurse / Date

- [ ] Admit Patient  
- [ ] Recertification  
- [ ] Resumption  
- [ ] Diagnosis(es) / ICD 9  
- [ ] PT  
- [ ] OT  
- [ ] ST  

**Duties / Responsibilities - Refer to PT POT or PT Re-Eval POT**

- [ ] Home Health Aide  
- [ ] Personal Care Aide for personal care  
- [ ] Waiver Personal Care Aide for personal care duties  
- [ ] Waiver Homemaking Aide for homemaking duties  
- [ ] Waiver Respite Aide for respite duties  
- [ ] Diet  
- [ ] Safety / Infection Control Measures: ____________

### Signature of Physician / Date

- [ ] Goals

**Discharge Goal(s)**

- [ ] Skilled Nurse
- [ ] Fill Medication Pack
- [ ] IV Therapy

- [ ] Injection
- [ ] Wound Care

- [ ] Weight every visit
- [ ] Pulse Oximeter
- [ ] Venipuncture
- [ ] Skilled Assessment of

- [ ] Instruct in

- [ ] Case Management for

- [ ] Other

- [ ] Medications

- [ ] Social Needs

- [ ] Environmental Needs:

**Prognosis**

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Guarded
- [ ] Poor