Cincinnati Children's Hospital Medical Center

PHYSICIAN'S ORDER FORM

Name_____

MR#_____ DOB_____

All orders must be written in the metric system and include date, time, physician's signature and pager/phone number. Use ball point pen.

Weight _____KG Height _____CM BSA_____M^2 Sex ☐ F ☐M

Allergies: ☐ None ☐ Drug/Contrast ☐ Food ☐ Product/Latex Specifics:_____

Isolation Precautions: ☐ No ☐ Yes, Type_____

HOME HEALTH CARE NURSE VISITS for ASTHMA REFERRAL/ORDER

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Caregiver(s)	Relationship	Phone number (s)
		Home: Cell:
		Home: Cell:

Language: ☐ English ☐ Spanish ☐ Other_____ **Interpreter needed?** ☐ Yes ☐ No

Insurance:_____ **Hospital stay?** ☐ No ☐ Yes, Admission Date:_____ Discharge Date:_____

Diagnosis:_____ **Surgery:** ☐ N/A_____

History: ☐ **See CCHMC Discharge Summary** _____

_____

Medication/dose/frequency: ☐ **See CCHMC Medication Reconciliation**_____

_____

Asthma specialist involved with patient: ☐ CCHMC Pulmonary ☐ CCHMC Allergy ☐ Private Allergy

Skilled Nurse Visits:

☐ Start of nursing care visit within 14 days days from the date patient referred to Home Care.

If Ohio Medicaid: I had a face to face encounter on _____ (date). **Addendum:** The clinical findings support Home Health eligibility because _____.

☐ Resumption of Home Health within 48 hours of hospital discharge or _____ (date). Home Health to resume plan of care and visit frequency.

Frequency: 3-5 visits **Duration:** Over an 8 week period then reassess need and progress toward goals.

Orders:

- Asthma education and management
- Review action plan, medications, triggers and use of nebulizer.
- Asthma Control Test (ACT) score each visit.
- Last ACT score was _____ on _____ (if available)

Referral Source:_____ Phone #:_____ Pager #:_____

Attending Physician who will manage care of patient at home:_____

_____

Physician Signature/Credentials **PRINT NAME** **Date/Time** **Pager #**

Fax completed orders to Home Care Office (513) 636-2714 then place orders in CCHMC medical record.

Orders faxed on: (date) _____ **(at time)**_____**by (print name)**_____

DTA0123