PHYSICIAN ORDER

DATE:

TO: _____

_____

_____ Phone # _____

NPI #_____ Fax # _____

Please sign below confirming your verbal order concerning this patient:

Patient name: _____ Date of Birth _____

For the certification period _____-_____-_____ to _____-_____-_____

Diagnosis : _____

Problem: _____

_____

Frequency/Duration/Treatment
Orders/Intervention/Medications _____

_____

_____

Physician Signature:	Date:

☐ Summary of visits and/or discharge summary requested

Thank you for your prompt attention to this matter. Please return this signed form in the enclosed postage paid envelope or fax to 330.929.1454 or 330.929.7732.

_____, RN

PROFESSIONAL NURSING SERVICE
2497 State Road
Cuyahoga Falls, Oh 44223
330.929.5512 or fax 330.929.1454