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| **Recover Care MD Communication Form** | | |
| **Recover Care Contact**: | **Office Phone**: | **Fax Number**: |

***Dear Doctor – Recover Care is providing this client home care services in their senior community. We appreciate you giving us information about our mutual client.***

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| --- | --- | --- | --- |
| **Client Name**: | **Client DOB**: | **Date of Visit**: | **Allergies**: |

Please see client’s medication list attached. Please review, note changes, sign, and date so we can coordinate the most up to date medications.

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| **Current Concerns / Reason for Visit:** | |
|  | |
| **Report prepared by:** | **Date:** |
| **Physician Comments / Updates to Plan of Care** | |
|  | |
| **Discontinued Orders/ Treatments** | |
|  | |
| **Next Appointment Date:** | |
| **Physician Signature:** | **Date:** |
| **Recover Care Staff RN Signature:** | **Date:** |
| ***RN's signature reflects that staff have been notified of relevant changes and the plan of care and service plan have been updated if necessary*** | |