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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** |
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| **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***  |