European Expert Care Agency, Inc
110 Norman Ave. Brooklyn, NY 11222
Tel (718) 349-0099 Fax (718) 389-0172

PHYSICIAN'S PLAN OF TREATMENT

DATE OF ORDER: _____

M.D. **Initial** **Renewal** **Change**

NAME_____

ADDRESS_____

_____

Patient:

NAME_____ **DOB**_____ **SEX** _____

ADDRESS_____

ALLERGIES: _____ ACT. **PERMITTED**: _____

DIAGNOSIS (ES): _____

PROGNOSIS: _____ **FUNCTIONAL LIMIT:** _____

MENTAL STATUS: _____

DIET: _____**FLUID** _____

PREVIOUS MED. HX. _____**REHAB POTENTIAL** _____

PATIENT TEACHING: _____

SPECIFIC THERAPY ORDERS: _____

TREATMENTS: _____

TYPE OF SERVICE: **RN** **LPN** **HHA** **PCA**

FREQUENCY _____

MEDICATIONS

Name **Dosage** **Route** **Frequency**

SIGNATURE OF M.D. _____ **DATE** _____