

MD ORDERS AND PLAN OF CARE

1. Patient's Prime No.:	2. Provider No:
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3. Patient's Name and Address:	4. Provider's Name, Address and Telephone Number:
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5. Date of Birth:	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F
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7. Principal Diagnosis:

8. Surgical Procedure:

9. Other Pertinent Diagnoses:

10. Respiratory Function/Status

11. Allergies:

12. Code Status:

13.A. Functional Limitations			13.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		

14. Mental Status	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other

15. DME and Supplies:

16. Safety Measures:

17. Nutritional Req.:

18. Treatments:

19. Medications:

20. Nurse's Signature:

21. Date:

22. Physician's Name and Address:

23. Attending Physician's Signature and Date Signed:

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.