Visiting Nurse Service Of New York
Home Care
We Bring The Caring Home

PLAN OF CARE

New York Presbyterian Hospital
Columbia Presbyterian Center
Home Health Services Request
622 West 168th Street
New York, NY 10032

INITIAL___SOC_____RESUMPTION___ VISIT DATE_____

VNS MRN_____ FACILITY MRN_____

TEAM_____ PROGRAM CODE_____PRODUCT CODE_____

Patient Name: Last	First	MI	
SS#	Date of Birth	Sex	
Address		Bldg/Apt	
City	State	Zip	
Phone	Lives with	Primary language	Understands English
Medicare #	Medicaid #		
Other Insurance	Insurance Comments		
Patient Assessed Yes No	Facility Admit Date	Facility Discharge Date	
Community MD: Last	First	Phone/Pager	
Address			
Emergency Contact/Relationship		Phone	
Primary Diagnosis/Date			
Other Diagnoses/Dates			
Surgical Procedure(s)/Date(s)			

Reason for Hospitalization (include chief complaint, past medical history, course of treatment, test results, status at discharge, etc.)

Clinical Assessment (include system review, functional and cognitive limitations, wound description/measurements, etc.)

Social Assessment/Support System (include safety and environmental concerns, pets, etc.)

Mutual Care Agreement required? Yes No Name Relationship Phone

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Plan of Care 2
Patient Name_____

MEDICATIONS					Allergies
Name	**Dose**	**Frequency**	**Route**		**VITAL SIGN RANGE**
					BP P
					T R
					HT WT Pain (0-10 scale)
					Parameters to call MD:
					BP: < _____**>** _____
					Glucose: **<**_____**>**_____
					Labs:
					Diet/Nutritional Requirements

Skilled Services **(include type of discipline, visit frequency and skilled interventions/treatments for each discipline)**

DME/Supplies: Items required

Verified in home (include date and name of person who verified)

Other Services

POC completed by: **Phone/Pager**

MD signing POC: Last **First** **Phone/Pager**

MD Signature: **Date:**