Devotion Home Health Care, LLC MED8891
11201 N Tatum Blvd, Suite 300
Phoenix, AZ 85028-6039
Phone: 480-415-4423 Fax: 14809923089

PHYSICIAN VERBAL ORDER (487)

DATE ORDER CREATED: 09/16/2026	**PATIENT INFORMATION**	
ORDER ID: 1184/735	**PATIENT NAME:** Julia Bode	**DOB:** 02/15/1964
AGENCY ASSIGNED ID: 1447	**ADDRESS:** 12374 N 136TH PL, SCOTTSDALE, AZ 85259-	
CERTIFICATION PERIOD: 09/15/2026 to 11/13/2026	**PHONE:** 602-625-9958	
PHYSICIAN FACE-TO-FACE DATE: 09/01/2026		

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: Wound Care, Decreased Activity tolerance, immunocompromised and has multiple comorbidities, medically contraindicated and/or difficult to leave the home: Immunosuppressed, SOB with exertion/activity and requires rest periods, Unable to ambulate short distances without rest, and open wounds on her chest.

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: Because our patient is immunocompromised and has multiple comorbidities.

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	Request to add prescription strength Lidocaine gel for dressing changes due to severe pain during wound care. Please add Colace or equitable stool softener 50mg QD to BID for constipation prevention and MiraLAX as needed for acute constipation due to opioid use.

PHYSICIAN INFORMATION	
PHYSICIAN NAME: GIRALDO KATO, MD	
ADDRESS: 2222 E HIGHLAND AVE STE 400, PHOENIX, AZ 85016-4880	
PHONE: 602-277-4868	**FAX:** 16022309350

VERBAL ORDER AUTHORIZATION	
By signing below, I acknowledge the verbal order(s) above and agree to follow this plan of care.	
PHYSICIAN SIGNATURE Signature: _____ Date: _____	**STAFF SIGNATURE (RECEIVED BY)** Signature: *Electronically Signed by DELGADO, SN, MELISSA* Date: *09/16/2026*

IMPORTANT: This verbal order must be authenticated by the physician and maintained in the patient's medical record.