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: 1184/733	**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	Wound care supply list and orders:
2	Xeroform 4x4 and 5x9 - 30 packages each monthly
3	Aquacel Ag 8"x12" and 6"x6" - 30 packages of each monthly

4	3M Kerramax Care Super Absorbent dressings 8"x12" and 4"x4" - 30 packages of each monthly
5	Sterile gauze - 90 packages monthly
6	Dakin's solution - 2 bottles monthly
7	Adhesive remover pads - 1-2 boxes monthly
8	No sting Barrier prep wands - 25 count box monthly
9	Hypafix or Medipore tape - 2 large rolls monthly
10	Lidocaine gel
11	Current wound dimensions 16cmLx40cmWx1.2cmD with additional unmeasurable tunnels and areas of undeterminable depths. Wound care every other day to daily as needed for saturation, soiling or dislodgement

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	**STAFF SIGNATURE (RECEIVED BY)**
Signature: _____	Signature: *Electronically Signed by DELGADO, SN, MELISSA*

Date: _____	Date: *09/16/2026*

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