Evergreen Home Health 239350
403 W Main Street Suite A1
Gaylord, MI 49735-1887
Phone: 989-214-1114 Fax: 866-410-7843

PHYSICIAN VERBAL ORDER (487)

DATE ORDER CREATED: 09/15/2026	**PATIENT INFORMATION**
ORDER ID: 1195/1420	**PATIENT NAME:** Donald Lauderbaugh — **DOB:** 08/30/1939
AGENCY ASSIGNED ID: 914	**ADDRESS:** 17535 Sunrise Lane, HILLMAN, MI 49746-
CERTIFICATION PERIOD: 08/14/2026 to 10/12/2026	**PHONE:** (989) 742-4401
PHYSICIAN FACE-TO-FACE DATE:	

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: - Home health referral ordered at time of discharge for PT/OT services. Source: Home Health Referral Order dated 08/12/2026, PDF p. 13. - Recent course includes a left intertrochanteric femur fracture treated with left trochanteric nailing on 06/04/2026, followed by skilled rehabilitation. Therapy notes document continued work on lower-extremity/core strength, balance, gait, transfers, ADLs, and discharge planning. Source: NP/PA Progress Note dated 08/10/2026, PDF p. 16; PT notes dated 08/10/2026 and 08/11/2026, PDF pp. 57-58; OT note dated 08/11/2026, PDF p. 14. - Active issues during the SNF stay also included chronic Foley catheter management/UTI monitoring, chronic anemia with low hemoglobin and positive hemoccult testing, and a left-hand skin wound. Source: Medication Review/Orders, PDF pp. 4-9; Progress Notes, PDF pp. 16-56.

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: medical condition could get worse if patient leaves home

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	Authorization changes of SN skill Total Visits: 1 and Visit Freq: WK6: 1 (09/13/26-09/19/26)

2	Authorization changes of PT skill Total Visits: 9 and Visit Freq: WK1: 1 (08/14/26-08/15/26),WK2: 1 (08/16/26-08/22/26),WK3: 1 (08/23/26-08/29/26),WK4: 1 (08/30/26-09/05/26),WK5: 1 (09/06/26-09/12/26),WK6: 1 (09/13/26-09/19/26),WK7: 1 (09/20/26-09/26/26),WK8: 1 (09/27/26-10/03/26),WK9: 1 (10/04/26-10/10/26)
3	08/31/2026 patient_goal: no goal - eval only, Target Date: 10/12/2026,
4	09/01/2026 procedure: cough/deep breathing exercises, Notes: , incentive spirometer, Notes: , equipment training, Notes: , work simplification/energy conservation, Notes: ,
5	08/28/2026 teach: lifestyle modifications to manage cardio-respiratory condition including diet changes and regular exercise; strategies to control shortness of breath and home remedies to keep lungs healthy, Target Date: 10/12/2026, therapeutic exercises, Target Date: 10/12/2026, therapeutic modalities, Target Date: 10/12/2026, equipment training, Target Date: 10/12/2026, work simplification/energy conservation, Target Date: 10/12/2026,
6	08/28/2026 goal: patient/caregiver recalls
7	* lifestyle modifications to manage respiratory condition including
8	* diet changes and regular exercise
9	* strategies to control shortness of breath
10	* home remedies to keep lungs healthy
11	* recalls related medication(s) purpose, schedule, Target Date: 10/12/2026, patient/caregiver recalls
12	* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
13	* teach relaxation skills and diversional activities

14	* recalls related medication(s) purpose, schedule, Target Date: 10/12/2026, Oral Hygiene - 06. Independent, Target Date: 10/12/2026, Toileting Hygiene - 06. Independent, Target Date: 10/12/2026, Shower/Bathe Self - 06. Independent, Target Date: 10/12/2026, Lower Body Dressing - 06. Independent, Target Date: 10/12/2026, Don/Doff Footwear - 06. Independent, Target Date: 10/12/2026, Eating - 06. Independent, Target Date: 10/12/2026, Upper Body Dressing - 06. Independent, Target Date: 10/12/2026,
15	08/31/2026 discharge_plan: patient will be responsible for managing treatment, Target Date: 10/12/2026,

PHYSICIAN INFORMATION

PHYSICIAN NAME: DAVID DARGIS, DO

ADDRESS: 109 S 13 HARRINGTON ST, ALPENA, MI 49707-1609

PHONE: (989) 356-2400	**FAX:** 19893542606

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 LUBELAN, RN, SAMANTHA*
Date: _____	Date: *09/15/2026*

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