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: 08/31/2026	**PATIENT INFORMATION**	
ORDER ID: 1195/1093	**PATIENT NAME:** Shelly Gyles	**DOB:** 01/16/1975
AGENCY ASSIGNED ID: 755	**ADDRESS:** 200 TOEPHER DR APT 1, HOUGHTON LAKE, MI 486298296-	
CERTIFICATION PERIOD: 08/17/2026 to 10/15/2026	**PHONE:** (231) 433-9203	
PHYSICIAN FACE-TO-FACE DATE: 05/14/2026		

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: PATIENT IN NEED OF HOME HEALTH TO COME IN AND ASSIST WITH WOUND CARE AND DAILY ADLS. EVERGREEN HOME HEALTH. THIS IS AN URGENT REFERRAL. PATIENT HAS WEEPING WOUNDS ON LEGS AND LYMPHEDEMA, OPEN WOUND ON RIGHT HEEL.

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: Need for assistance at home and no other household member able to render care

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	Authorization changes of PT skill Total Visits: 2 and Visit Freq: WK5: 1 (09/13/26-09/19/26),WK6: 1 (09/20/26-09/26/26)
2	08/27/2026 patient_goal: add patient-stated goal, Target Date: 10/15/2026,

3	08/27/2026 teach: 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, teach relaxation skills and diversional activities, Target Date: 10/15/2026, related medication(s) purpose and schedule, Target Date: 10/15/2026, symptoms requiring physician notification, Target Date: 10/15/2026,
4	08/27/2026 discharge_plan: add discharge plan, Target Date: 10/15/2026,

PHYSICIAN INFORMATION

PHYSICIAN NAME: DARCIE DOHNAL, MD

ADDRESS: 14734 PARK AVENUE BLDG A CHARLEVOIX PRIMARY CARE, CHARLEVOIX, MI 49720-1927

PHONE: (231) 547-6554	**FAX:** 12313927332

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: *08/31/2026*

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