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: 09/18/2026	**PATIENT INFORMATION**	
ORDER ID: 1195/1521	**PATIENT NAME:** SHERRY ABBE	**DOB:** 12/01/1960
AGENCY ASSIGNED ID: 719	**ADDRESS:** 269 E KNEELAND RD, MIO, MI 48647-	
CERTIFICATION PERIOD: 08/16/2026 to 10/14/2026	**PHONE:** (989) 390-3380	
PHYSICIAN FACE-TO-FACE DATE:		

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: Chronic obstructive pulmonary disease w (acute) exacerbation

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: There exists a normal inability to leave the home. Leaving home requires a considerable and taxing effort. Because of illness or injury, the person needs a walker and assistance of another person in order to leave their place of residence.

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	09/11/2026 procedure: home exercise program, Notes: Therapist to instruct seated, standing and/or reclined home exercises including but not limited to any or all of the following as tolerated: active or band resisted/assisted ankle pumps, circumduction, hip flexion, adduction, and/or abduction, range of motion for Lower extremity joints of knees, hips, and/or ankle/foot. Core strengthening; neuromuscular education. Written home exercises provided and program may be modified and/or progressed as tolerated., Physical Therapy Procedures and Protocols for PTA, Notes: Physical Therapist Assistant (PTA) may perform the procedures listed in this care plan, including reasonable and appropriate

	procedures listed in this care plan, including reasonable and appropriate progression of interventions listed. Prior to providing or continuing care, PTA must immediately notify and speak with supervising PT by phone call if the patient experiences a significant, unanticipated change in condition, functional status, or response to treatment.,

PHYSICIAN INFORMATION	
PHYSICIAN NAME: MUHAMMAD ABDELHAI, MD	
ADDRESS: 11899 M 32, ATLANTA, MI 49709-9374	
PHONE: (989) 785-4855	**FAX:** 19893184606

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 STRICKLER, SN, SYDNEY* Date: *09/18/2026*

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