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: 08/20/2026	**PATIENT INFORMATION**
ORDER ID: 1195/715	**PATIENT NAME:** NORMAN PESONEN / **DOB:** 05/02/1935
AGENCY ASSIGNED ID: 691	**ADDRESS:** 4949 TARI LN, LEWISTON, MI 49756-
CERTIFICATION PERIOD: 07/26/2026 to 09/23/2026	**PHONE:** (989) 786-5610
PHYSICIAN FACE-TO-FACE DATE:	

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: Parkinsonism, unspecified

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

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	08/07/2026 procedure: home exercise program, Notes: Adding new HEP procedure with details: DISCONTINUED, 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.,

PHYSICIAN INFORMATION	
PHYSICIAN NAME: JENNIFER MCBRIDE, AGNP-C	
ADDRESS: 3040 BOURN ST, LEWISTON, MI 49756-8134	
PHONE: (989) 786-4877	**FAX:** 19897316723

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: *08/27/2026*

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