Evergreen Home Health
GROWING STRONGER EVERY DAY, WITH EVERGREEN HOME HEALTH.

Evergreen Home Health 239350
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Phone: 989-214-1114 Fax: 866-410-7843

PHYSICIAN VERBAL ORDER (487)

DATE ORDER CREATED: 09/01/2026	**PATIENT INFORMATION**
ORDER ID: 1195/1108	**PATIENT NAME:** Sue Braley / **DOB:** 10/23/1962
AGENCY ASSIGNED ID: 850	**ADDRESS:** 3150 GALLOWAY RD PO BOX 139, LUZERNE, MI 486360139-
CERTIFICATION PERIOD: 07/23/2026 to 09/20/2026	**PHONE:** (989) 889-4205
PHYSICIAN FACE-TO-FACE DATE: 07/21/2026	

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN: Symptoms identified support difficulty to leave home for medical services required.. post-op care

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: Symptoms identified support difficulty to leave home for medical services required

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	Authorization changes of PT skill Total Visits: 8 and Visit Freq: WK2: 1 (07/26/26-08/01/26),WK3: 1 (08/02/26-08/08/26),WK4: 1 (08/09/26-08/15/26),WK5: 1 (08/16/26-08/22/26),WK6: 1 (08/23/26-08/29/26),WK7: 1 (08/30/26-09/05/26),WK8: 1 (09/06/26-09/12/26),WK9: 1 (09/13/26-09/19/26)

PHYSICIAN INFORMATION

PHYSICIAN NAME: DAVID HUNTER, MD	
ADDRESS: 1910 EAST MILLER ROAD, FAIRVIEW, MI 48621	
PHONE: (989) 848-5644	**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	**STAFF SIGNATURE (RECEIVED BY)**
Signature: _____	Signature: *Electronically Signed by STRICKLER, SN, SYDNEY*
Date: _____	Date: *09/01/2026*

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