



Client Code: _____ Client Phone: _____

FACILITY: _____ DATE: _____

Change Form for Pre-Existing Routine (Standing) Order

DO NOT USE FOR NEW ORDERS

Attention: Director of Nurses / Medical Director:

To ensure compliance with State law and the Office of the Inspector General of the Department of Health and Human Services, we require written authorization to change **pre-existing** Routine (Standing) Orders. Please enter change(s) to routine (standing) orders in the appropriate space below. Sign and date this form. Fax it to: (925) 692-5972. We will process the request.

Orders MUST be received before 3:30 pm Monday – Friday in order to be processed

Resident Name: _____ Sex: _____ Room # _____.

D.O. Birth: _____ Social Security #: _____.

Medicare/Medicaid #: _____ Insurance: _____.

Physician: (Full Last Name): _____ (Full First Name): _____.

Physician Phone: _____ Diagnosis Code: _____.

Pre-Existing Order: _____

Change Order to: _____ Effective Date: _____.

Discontinue Order On: (date) _____

Patient Discharged On: (date) _____

Authorized by: _____ Date: _____.

CONFIDENTIALITY NOTICE: *The medical information in the FAX message is confidential and privileged. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient, you are hereby notified that you have received this FAX message in error and that the review or further disclosure of the information contained therein is strictly prohibited. If you have received this message in error, please notify us immediately at 925-692-5607 to arrange for return of the original FAX transmission by mail*