MAIER FAMILY PHARMACY
Plan of Treatment – FAX to 712-881-1206

Please review this Plan of Treatment, make any necessary changes, sign and date and return to Maier Family Pharmacy.
We cannot provide clinical assessments for your patient(s) without a signed Plan of Treatment on file.

If to be used as "blanket plan of treatment," please indicate by checking the box below:

❑ For all my patients referred to Maier Family Pharmacy

Patient Name:____

Address:____

Diagnosis:____

Secondary Diagnosis:____

Maier Family Pharmacy pulmonary assessment may include vital signs, spot and/or overnight pulse oximetry and breath sounds/chest assessment. These will be performed:

❑ PRN **Other:**____
(Specify frequency – i.e., 3 months, 6 months, etc.)

Maier Family Pharmacy will contact physician when patient is not compliant with written prescription, or when:

Oxygen saturation is below 90% or _________________________**.**

Blood Pressure is below:__________**mmHg or above:**__________**mmHg.**

Other:____

Please describe any precautions or limitations that would affect the plan of care:

____

Physician's Signature:__________________________________ **Date:**_______________

Physician's Name:____

Physician's Address:____

Physician's Telephone:______________ **Fax:**_________________