EXTENDED HEALTH CARE QUALIFICATION

Date ________________________

To Whom It May Concern:

This letter is to confirm that my patient________________________

has been diagnosed with______________________________________

requiring (name of surgery/procedure)_________________________

This patient will be discharged from___________________________

and returning to their home for recovery. This patient is currently acutely ill. Therefore it is my decision that due to medical necessity this patient needs to have continued nursing care following their discharge. I am requesting that this patient have the assistance of a Registered Nurse to provide post-operative care during their recovery.

Sincerely,

Dr.________________________ Practitioner # ______________

Office Address ____

Phone Number _______________________