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INTERIM ORDERS

Send To		Primary Physician
Christine A Will, MD Hawthorn Medical Associates 531 Faunce Corner Rd. North Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-2535		Christine A Will, MD Hawthorn Medical Associates 531 Faunce Corner Rd. North Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-2535

Medical Record No.	Insurance	Start of Care	Certification Period
6544015	Medicare	05/23/2025	05/23/2025 Through 07/21/2025

Patient	DOB	Sex
Whewell, Yvonne A 2609 Acushnet Ave New Bedford, MA 02745	04/08/1952	F

Medications (Dose/Frequency/Route)	senna 2 tablets oral once a day PRN Constipation
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Tanya Sherman RN *E-Signature* 06/26/2025 @ 12:13 PM VO Date 06/19/2025 12:13 PM

Orders for Discipline and Treatments	PT: d/c Recommend Equipment As Needed
Goals/Rehabilitation Potential/Discharge Plans	PT Goals: Pt will ambulate with a RW and Supervision 2x15 feet to improve ambulation in the home to improve access to all rooms within cert period. d/c Patient will perform standing efforts at sink with bil AFOs and 1 CGA to initiate pre gait training activities within cert period. d/c Patient will perform supine <> sit transfers and bed<> WC/ commode transfers independently to reduce dependency on caregivers within cert period. Pt will demonstrate improved B LE strength for hip flexors/extensors to 3+/5 or greater to improve transfers to an independent level. within cert period
Clinical Summary	CURRENT LEVEL OF FUNCTION: Pt is progressing fairly well with skilled PT services at this time and has been free from falls. She is making progress toward her PT goals. Pt is performing bed mobility independently and transfers with CL Supervision with ongoing cues for safety and hand placement as pt tends to pull up using the RW and sit down while holding the RW. Pt ambulates with a RW and CG with w/c follow short distances x10 feet with decreased step length/height and a narrow BOS. She has difficulty with foot placement at times due to weakness and neuropathy, with some scissoring at times. BARRIERS/CHALLENGES: Pt continues to require increased assistance with all mobility and ambulation from her pervious baseline level. She continues with decreased strength, balance, endurance and increased pain. She continues to be at an increased risk of falls. SKILL/REASON FOR CONTINUED SERVICE: Skilled PT services are necessary to continue in order to address the endurance, strength, balance, gait and safety deficits, in order for pt to return to PLOF. Without PT services, the patient is at a significant risk for falls with injury, decreased quality of life and increased dependence on caregivers for mobility. This would result in a decreased quality of life. PT services are expected to improve the patients mobility to return to PLOF and decrease risk of falls. HOMEBOUND: Pt is currently homebound at this time as it is a taxing effort for pt to safely leave their home due to the above impairments, placing them at an increased risk of falls. 24/7 CNHC availability and red flags reviewed DISCHARGE PLANNING: 3-4 weeks ADJUSTMENT TO THE POC: Updated PT POC; continue 1x/wk POC REVIEW: Plan of care reviewed with Patient, who verbalizes understanding and agrees to continue to participate. Richard C Landis, PT

Clinician's Signature and Date	Richard Landis PT-MA Lic# 17803 *E-Signature* 06/23/2025 @ 02:25 PM VO Date 06/23/2025 02:25 PM

Orders for Discipline and Treatments	Diet: Start on 06/23/2025: Once every 14 das x 14 das
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Tanya Sherman RN *E-Signature* 06/19/2025 @ 10:54 AM VO Date 06/19/2025 10:54 AM

Orders for Discipline and Treatments	Diet: Once every 14 das x 14 das
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Deena Savage RN *E-Signature* 06/09/2025 @ 03:07 PM VO Date 06/09/2025 03:07 PM

Orders for Discipline and Treatments	SN: OT eval pending
Goals/Rehabilitation Potential/Discharge Plans	SN Goals: OT eval pending
Clinician's Signature and Date	Tanya Sherman RN (by Deena Savage *E-Signature* 06/09/2025 @ 10:33 AM) VO Date 05/23/2025 10:33 AM

Orders for Discipline and Treatments	OT: 1x/wk x 1 wk
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Jennifer Nielson OTR-MA Lic# 7586 *E-Signature* 05/30/2025 @ 03:10 PM VO Date 05/30/2025 03:10 PM

Orders for Discipline and Treatments	OT: Start on 06/01/2025: 1x/wk x 8 wks, PRNx4 Change in Functional Stat ADL/IADL Training. Assess Need For Adaptive Equipment & Order As Needed. Assess oxygen saturation as needed and report to physician if less than 88%. Assess vital signs and report the following to the physician: Temperature over 101.5, Systolic Blood Pressure over 160, or less than 90, Diastolic Blood Pressure over 90, Heart Rate less than 50, or greater than 120, Respirations greater than 26. C- Assess patient pain. Caregiver Instruction and Training. Energy Conservation. Fall Prevention Instruction. Functional Mobility/Transfer Training. Home Safety/Fall Prevention Training. Instruction and progression of Home Exercise Program. Involve Pt In Activities to Improve Endurance. Involve Pt In Activities to Improve Functional Balance. Muscle Re-education. Therapeutic Exercise. Wheelchair mobility Training
Goals/Rehabilitation Potential/Discharge Plans	OT Goals: Patient Stated Personal Goal: Long Term Goal: "to be able to cook for myself from my w/c" within cert period. Long Term Goal: Patient will safely perform UB/LB sponge bathing /dressing and toileting tasks indep after set up; demonstrating improved knowledge of joint protection, work simplification, compensatory strategies and adaptive equipment use prn. within cert period. Long Term Goal: Patient will safely perform kitchen mobility indep from w/c ; including light meal prep/ transport and clean up afterwards, demonstrating improved knowledge of joint protection, work simplification and compensatory strategies. within cert period. Long Term Goal: Good Understanding & Carryover of Energy Conservation Techniques within cert period. Long Term Goal: Independent HEP within cert period. Pt to remain safe at home as evidenced by no reported falls. within cert period. Patient will demonstrate indep commode & w/c transfers w/ appro AE in place demo good safety, pacing and body mechanics. within cert period. Pt will increase (B) UE strength by half grade to increase (B) UE function for ADL/ functional mob & xfers. within cert period
Clinical Summary	REASON FOR REFFERAL: Pt seen this date by skilled OT for home eval. Pt referred to skilled OT for ADL/home safety assessment. Patient is a 73-year-old female s/p lengthy hosp/ rehab stay. Pt was initially hospitalized 1/2025 due to osteomyelitis, discitis at L4-L5 as well as epidural abscess from L3 - L5. Patient completed a course of vancomycin. Patient was admitted to the Oaks SNF on 1/30/25 for STR but had multiple rehospitalizations due to AKI with severe hyperkalemia and UTIs. She was dc home on 5/22/25 w family support / home care services. Primary diagnosis: AKI, Lumbago, Sciatica, DISH, and osteomyelitis. PMH: Slow transit constipation, discitis lumbar region, lumbago with sciatica, claustrophobia, TIA, cerebral infarct without residual deficits, generalized anxiety, COPD, DM, neuromuscular dysfunction of bladder, retention of urine, HTN, heart and chronic kidney disease without complications, occlusion, stenosis of left carotid artery, hyperlipidemia, long QT syndrome, hypoosmolality, hyponatremia. Soc HX/PLOF: Pt lives with husband in a single-family two-story home. There are 3-4 STE w/ rail which husband has installed a temporary ramp. Bedroom and full bathroom on the second floor which is non-accessible to patient at this time. There is half bath on first floor that is also

	non-accessible d/t doorway too narrow for w/c. Therefore, she is sleeping on couch and utilizing commode / sponge bathing in living room area. PLOF : pt was indep w/ all areas w/ no AD, indep w/ ADL/IADLs, driving. EQUIPMENT: see OT assessment for details CODE STATUS: HCP - Husband Ted, full code. COGNITION: A+Ox3, pleasant and cooperative CURRENT LEVEL OF FUNCTION: FUNCTIONAL MOB/TRANSFERS: bed mob on couch SBGA, couch <> commode SBGA, couch <> w/c SBGA. Pt is non-ambulatory. Pt xfers from couch <> commode, couch <> w/c by sliding over from one surface to another w/ out use of slide board. ADL/IADL: sponge bathing set up/ SBGA, dressing set up/ SBGA, toileting SBGA - Pt manages clothing for toileting while seated on couch prior to xfer. She completes hygiene for toileting seated on commode hiking one hip up at a time and weight shifting side to side, Bathing of peri area done seated on commode weight shifting side to side and hip hiking. tub xfer unable , meal prep dep PAIN: LEs UE ROM: wfl UE STRENGTH: 3+/5 FALLS: hx falls but no fall since home from SNF AE RECOMMENDATIONS: TBA further Pt presents w/ the following: LE pain/ neuropathy, significant LE weakness, inability to stand, non-ambulatory, decreased activity tolerance, UE ROM weakness, fall risk all impeding pt's ADL abilities. Pt presents w/ decreased level of function ADL, functional mob compared to baseline. SAFETY: fall risk SKILL/REASON FOR HOMECARE: Pt will benefit from skilled home OT for home safety/fall prevention, ADL/ adaptive equipment training, work simplification/energy conservation, compensatory strategies training and UE HEP with focus on improving safety/indep during ADLs, functional transfer/ functional mobility. Without skilled home OT services, patient is at risk for fall/injury, increased dependence upon caregivers and decreased quality of life. HOMEBOUND: Pt is homebound d/t non-ambulatory, w/c, ramp and assist of 1 to leave home, pain, considerable taxing effort, fall risk. ESTIMATED # VISITS: 4-5 24/7 CNHC availability and red flags reviewed POC REVIEW: Plan of care reviewed with pt who verbalizes understanding and agrees to participate. MD was informed of patients POC. Consent form reviewed with pt. Pt verbalized understanding. This writer witnessed pt signing the consent form and it was scanned to office. Jennifer Nielson, OTR/L
Clinician's Signature and Date	Jennifer Nielson OTR-MA Lic# 7586 *E-Signature* 05/30/2025 @ 03:10 PM VO Date 05/30/2025 03:10 PM
Medications (Dose/Frequency/Route)	d/c Fleet Enema 19 g-7 g/118 mL enema 1 each rectal once a day PRN Constipation *DC Ordered By: Will, Christine A MD (Internal Medicine), 5/27/2025* d/c Tussin DM 10 mg-100 mg/5 mL liquid 10 milliliter oral every 4 hours PRN cough *DC Ordered By: Will, Christine A MD (Internal Medicine), 5/27/2025*
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Tanya Sherman RN *E-Signature* 05/27/2025 @ 04:52 PM VO Date 05/27/2025 04:52 PM

Physician's Signature**X** Date**X**

Christine A Will, MD

Date HHA Received Signed POT	(Sent 7/1/2025 10:59 AM)