Community Nurse Inc
62 Center Street
Fairhaven, MA 02719
(508) 992-6278
Fax (508) 997-3091

INTERIM ORDERS

Send To		Primary Physician
Shan Qin, MD Hawthorn Medical Associates 531 Faunce Corner Rd Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-0876		Shan Qin, MD Hawthorn Medical Associates 531 Faunce Corner Rd Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-0876

Medical Record No.	Insurance	Start of Care	Certification Period
6675015	Medicare	06/16/2025	06/16/2025 Through 08/14/2025

Patient	DOB	Sex
Sullivan, Dennis B 30 Sarah Beth Lane Rochester, MA 02770	06/26/1937	M

Orders for Discipline and Treatments	ST: 1x/wk x 1 wk
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Melanie Cardoza SLP- MA Lic # 4620 (by Kathy Lee Rodrigues *E-Signature* 07/07/2025 @ 01:58 PM) VO Date 06/25/2025 01:58 PM

Orders for Discipline and Treatments	ST: Start on 06/29/2025: 1-2x/wk x 7 wks
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Melanie Cardoza SLP- MA Lic # 4620 (by Kathy Lee Rodrigues *E-Signature* 07/07/2025 @ 01:57 PM) VO Date 06/25/2025 01:57 PM

Orders for Discipline and Treatments	ST: Start on 06/30/2025: 1-2x/wk x 7 wks Establish Home Management Program. Expressive Language Therapy. Teach Compensatory Strategies, Oral Expression Strategies, Pt/CG Nature of Disorder & HEP
Goals/Rehabilitation Potential/Discharge Plans	ST Goals: Goal: The patient will produce multiple sentences placing pauses in appropriate places in 80% of opportunities given frequent maximal verbal cues.. Long Term Goal: Patient Will Increase In Communication. Patient Stated Personal Goal- Goal: I want to be able to have a conversation. Patient will use compensatory strategies to improve attention, word retrieval, short term memory and safety within current environment 80% of the time.
Clinical Summary	ST evaluation summary: Pt is a very pleasant 87-year-old male. He was seen for admission to Community Nurse on 6/16/25 by SN: "referred by primary care physician for home care services, including Nursing, PT, and OT, with a primary diagnosis of Parkinson's disease. Primary DX: Parkinson's disease without dyskinesia". Referred for home ST to addressdecline in communication skills. . PMH: Parkinson's disease, type 2 diabetes, nephrolithiasis status post laser lithotripsy, prostate cancer, hyperlipidemia, anemia, retinal detachment, chronic kidney disease stage 3, low back pain Soc HX: Patient lives with his wife in a 2 story townhouse. His wife is present, difficult difficult difficulties in communication due to low volume, imprecise, articulation, and word finding difficult difficulties in conversations CODE STATUS: Full code COGNITION: A&Ox3, wife reports he is forgetful and confused at times; very pleasant and cooperative. CURRENT LEVEL OF FUNCTION: Pt was seen today for a speech and language evaluation. Auditory comprehension skills appear to be WFL. Patient was able to recognize common objects with 100% accuracy. Identifying items named serially, understanding sentences and repeating up to 5 digits were performed with 100% accuracy. Oral Expression: Patient was able to repeat monosyllabic words and phrases upon request. Patient was able to complete

	sentences, give biographical information, express basic ideas. Patinet had more difficulty defining words. Patient was also able to name pictures of common objects with 90% accuracy however patient is demonstrating difficulty with higher level word retrieval skills. Cognitive: Patient was oriented x3. He was able to generate ideas in categories, sequence three step ADLs and functional problem solve. Oral Mech. Exam: A cursory oral mechanism exam was used to assess labial lingual strength, ROM and coordination. Labial and mandibular strength were found to be adequate. Tongue movement and strength was also adequate. During prolongation of "ah" it was noted that voice quality was "harsh and breathy" while the duration of the vowel was 5 seconds indicating the lack of respiration needed for speech... SAFETY: High risk for falls; The home has 5 stairs with a rail-to exit/enter in front, 4 stairs with a rail-to exit/enter thru the garage; Bedroom and full bathroom are on the 1st floor. SKILL/REASON FOR THERAPY SERVICES: Pt requires skilled ST for word retrieval and speech intelligibility to include oropharyngeal exercise program, speech intelligibility strategies and HEP. Homebound: Parkinson's disease, decreased flexibility/strength, impaired balance/unsteady gait, high risk for fall, requires assist of a person and device-including a transport W/C for distances, has stairs to exit/enter, taxing effort to leave the home. ESTIMATED # VISITS: 8 24/7 CNHC availability and red flags reviewed POC REVIEW: Plan of care reviewed with pt and his wife, who verbalized understanding and agree to participate. MD was informed of patient's POC. Consent form reviewed with pt and his wife, both verbalized understanding. This writer witnessed pt signing the consent and form scanned to office. Melanie Cardoza MS CCC -SLP
Clinician's Signature and Date	Melanie Cardoza SLP- MA Lic # 4620 *E-Signature* 06/25/2025 @ 10:31 PM VO Date 06/25/2025 10:31 PM

Orders for Discipline and Treatments	HCA: Start on 06/22/2025: 2x/wk x 1 wk
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Matthew Germano OTR-MA Lic# 7656 *E-Signature* 06/25/2025 @ 05:31 PM VO Date 06/25/2025 05:31 PM

Orders for Discipline and Treatments	Diet: high calorie, high protein diet
Goals/Rehabilitation Potential/Discharge Plans	Diet Goals: Diet eval within cert period
Clinician's Signature and Date	Barbara Canuel *E-Signature* 06/23/2025 @ 10:07 PM VO Date 06/23/2025 10:07 PM

Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Matthew Germano OTR-MA Lic# 7656 *E-Signature* 06/23/2025 @ 08:12 PM VO Date 06/23/2025 08:12 PM

Orders for Discipline and Treatments	OT: Start on 06/16/2025: Once every 14 das x 9 das, 1x/wk x 1 wk, 1-2x/wk x 3 wks, 1x/wk x 4 wks, PRNx2 Change in Functional Stat Patient Risk for Emergency Room use or Hospitalization is assessed to be: Low and will be addressed with measures focusing on: ECWS/pacing education, bathroom txfr training with proper DME/AD setup, correct caregiver support, ADL training and UE HEP. Adaptive/ADL Training. Assess Fine & Gross Motor Control Activities. Assess Need For Adaptive Equipment. 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. Coordination Activities. Energy Conservation. Functional Balance training. Instruction and progression of Home Exercise Program. Muscle Re-education. Neuromuscular Education. OT Evaluation. Practice Toilet Transfers. Practice Tub Transfers. Therapeutic Exercise
Goals/Rehabilitation Potential/Discharge Plans	OT Goals: Long Term Goal: Pt will demo SBA UB and Min A LB selfcare task demo after item setup by caregivers within cert period. Long Term Goal: Pt will demo SBA fxnl toilet txfr and CGA fxnl shower txfr with proper DME setup and no evidence of falls within cert period. Long Term Goal: Good Functional Balance within cert period. Short Term Goal: Good Understanding & Carryover of Energy Conservation Techniques within cert period. Long Term Goal: Improve Gross/Fine Motor Skills within cert period. Long Term Goal: Patient BIL Arms strength will increase from 3/5 to 4-/5 for easier and safer transfers/mobility and ADLs/IADLs within cert

	period. Patient Stated Personal Goal- Goal: No falls, no hospitalization, regaining indep with ADL demo within cert period
Clinical Summary	Skilled OT EVAL - Pt is an 87 year old male, referred by PCP with primary diagnosis of Parkinson's disease. Skilled OT services referred to assess BUE AROM/coordination and muscle weakness, pain and fatigue with task demo, ADL/IADL participation & bathroom txfr/fxnl mobility demo with proper AD/DME setup. Primary Dx: Parkinson's disease without dyskinesia PMH: Parkinson's disease, DM2, nephrolithiasis s/p laser lithotripsy, prostate cancer, hyperlipidemia, anemia, retinal detachment, chronic kidney disease stage 3, low back pain. Soc HX: Patient lives with his wife in a 2 story SFH. Wife and Dgt present at time of OT EVAL. Pt is new to RW (x 3 mos) and was using SC prior to walker. Pt was Indep to SBA with UB/LB dressing, bathing/showering, grooming, toileting and self feeding. Equipment: PERS, Rollator walker, gait belt, power lift recliner, shower stall-low built in seat/suction cup grab bar, commode over the toilet, transport W/C in the garage. CODE STATUS: FULL CODE COGNITION: A&O (x2-3), can be forgetful / confused at times, very pleasant and cooperative. CURRENT LEVEL OF FUNCTION: Patient requires MOD-MAX A for safe UB/LB self-care task demo and is Dependent with IADL demo in home setting. Patient ambulates with Rollator and MOD A (x1) with use of gait belt. Patient requires MOD assist for safe chair, toilet (with commode overlay), and shower stall with built-in shower seat and one suction grab bar. OTR recommended acquisition of new adjustable tub seat/no back. Pain and fatigue noted daily. Patient presents with elevated fall risk 2* decreased step length, decreased step height, and impaired vision. Pt presents with approx 0-116 Bil shld AROM flex against gravity (3-/5 mmt), WFL extension, reduced ABD/ADD, ER and intact IE, Bil elbow, wrist and hand AROM with 3/5 to 3+/5 muscle strength. Decreased GMC/FMC noted with task demo and intact Bil hand sensation awareness. HEP indicated to increase fxnl use of UE's and hands with task and txfr demo. SAFETY: Environmental modifications to bathroom include acquisition of adjustable tub seat, no back from local COA, and possibly one additional suction grab bar for shower stall. SKILL/REASON FOR THERAPY SERVICES: Skilled OT services indicated for BUE AROM, GM and FM coordination, ^ strengthening, ECWS training, pain management, ADL training , bathroom transfer/mobility training, and environmental modifications. HOMEBOUND: Pt is homebound 2* decreased strength, balance, coordination, ^ pain and fatigue, PD, + fall risk, Back pain, requires Rollator and assistance x1, which creates a taxing effort to leave the home setting. ESTIMATED # VISITS: 10 24/7 CNHC availability and red flags reviewed POC REVIEW: Plan of care reviewed with patient and family, who verbalize understanding and agree to participate. MD was informed of the patient's POC. Reviewed SOC assessment. OTA oriented to plan of care. Consent form/s reviewed with Dennis B Sullivan. Patient verbalized understanding. This writer witnessed Dennis B Sullivan signing the consent, and the form was scanned to the office. Matt Germano OTR/L
Clinician's Signature and Date	Matthew Germano OTR-MA Lic# 7656 *E-Signature* 06/23/2025 @ 07:40 PM VO Date 06/23/2025 07:39 PM

Orders for Discipline and Treatments	SN: PRNx10 telehealth
Goals/Rehabilitation Potential/Discharge Plans	
Clinician's Signature and Date	Heidi Gonsalves LPN *E-Signature* 06/19/2025 @ 09:03 PM / Kathy Lee Rodrigues RN *E-Signature* 07/07/2025 @ 02:57 PM VO Date 06/17/2025 11:41 AM

Orders for Discipline and Treatments	SN: Daily home monitoring of blood pressure.. Daily home monitoring of heart rate.. Home monitoring via HRS telehealth monitoring system.
Goals/Rehabilitation Potential/Discharge Plans	SN Goals: As a result of telehealth, patient will be able to: Understand disease process and verbalize symptoms to report to physician, maintain weight and/or vital signs within normal

	range, demonstrate understanding of medication regimen.. Improvement in selfmanagement of chronic disease.
Clinician's Signature and Date	Heidi Gonsalves LPN *E-Signature* 06/19/2025 @ 11:41 AM / Kathy Lee Rodrigues RN *E-Signature* 07/07/2025 @ 02:57 PM VO Date 06/19/2025 11:41 AM

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

Shan Qin, MD

Date HHA Received Signed POT	(Sent 7/8/2025 11:01 AM)