Order Number: 31867593

Printed: 5/30/2025 2:06 PM
Eastern Time Zone

AMEDISYS HOME HEALTH FALL RIVER, MA 4410
35 UNITED DRIVE SUITE 301
WEST BRIDGEWATER, MA 02379-1056
Phone: (508) 235-0425
Fax: (508) 675-3894

PHYSICIAN:

MANUELA MENDES, MD
289 PLEASANT ST SUITE 203
FALL RIVER, MA 02721

Phone: (508)679-1033
Fax: (508)675-2008
2nd Physician:
Send to Physician: Y
Verbal Order: N

CLIENT:

SIMOES, BALBINA A
177 MARCHAND ST
FALL RIVER, MA 02723-

SSN:
Medicare No.: 3MT7VP4KQ35
DOB: 12/31/1946
MR#: I7000394472601
CERT: 3/9/2025 to 5/7/2025
Order Read Back to Physician/Agent of Physician?: Y
ABN Delivered to Patient?: NA

Hospital MR No	Inpatient Facility	Admit Date	Discharge Date	Reason For Admission
	SAINT ANNE`S HOSPITAL SA0011439	1/26/2025	1/29/2025	SEPSIS, PNEUMONIA
	CLIFTON REHABILITATION NURSING CENT CL0001261	1/29/2025	3/8/2025	SEPSIS PNA

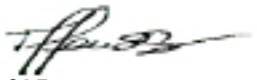
Order Date: 5/30/2025 1:47 PM **Order Type:** FACE TO FACE CLARIFICATION/ADDENDUM

Order Description:

I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND THAT I, OR A NURSE PRACTITIONER OR A PHYSICIAN'S ASSISTANT WORKING WITH ME, OR A PHYSICIAN WHO CARED FOR THE PATIENT IN AN ACUTE OR POST-ACUTE FACILITY, HAD A FACE-TO-FACE ENCOUNTER RELATED TO THE PRIMARY REASON THE PATIENT REQUIRES HOME HEALTH WITH THIS PATIENT ON 03/21/2025 .
BASED ON THE FINDINGS FROM THE FACE-TO-FACE ENCOUNTER LISTED ABOVE, I CERTIFY THAT THIS PATIENT IS CONFINED TO THE HOME AND NEEDED INTERMITTENT SKILLED NURSING, PHYSICAL THERAPY, AND/OR SPEECH THERAPY. THIS PATIENT IS UNDER MY CARE AND I HAVE INITIATED THE ESTABLISHMENT OF THE PLAN OF CARE FOR HOME HEALTH AND WILL PERIODICALLY REVIEW THE PLAN OF CARE.

ENTERED / TAKEN BY (ELECTRONICALLY SIGNED):	MARY MATUBIA, RN	**DATE:**	05/30/2025
APPROVED / PROCESSED BY (ELECTRONICALLY SIGNED):	MARY MATUBIA, RN	**DATE:**	05/30/2025
PHYSICIAN SIGNATURE:		**DATE:**	

Physician: Dr. Mendes, Manuela M.

Signature: 

Date: 6/5/2025

Clinician: Agency, Clinician

Signature:

Date: 5/30/2025

Electronically signed by Dr. Mendes, Manuela M. on 6/5/2025