Order Number:
13753435

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	3/24/2025	3/24/2025 to 5/22/2025	A5300244927401	227260

Patient's Name and Address:
BEATRICE P OLIVEIRA (508) 673-4585
51 MCGOWAN ST
FALL RIVER, MA 02723-

Provider's Name, Address and Telephone Number:
FALL RIVER - CENTERWELL HOME HEALTH F: (508) 675-6913
275 MARTINE STREET 104
FALL RIVER, MA 02723- P: (508) 672-0675

Physician's Name & Address: P: (508)679-2265 F: (508)646-0586

Dr. HANY A. MISTIKAWY
289 PLEASANT STREET
FALL RIVER, MA 02721

Patient's Date of Birth: 8/23/1947
Patient's Gender: FEMALE
Order Date: 3/24/2025 1:11 PM
Verbal Order: Y
Verbal Date: 3/24/2025
Verbal Time: 1:45 PM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
MICHELLE SILVA, RN / FLAVIA PEDRO RN, BD 3/23/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
I HOPE MY BELLY STAYS NOT HURTING

ICD-10
Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	J10.00	FLU DUE TO OTH IDENT FLU VIRUS W UNSP TYPE OF PNEUMONIA	ONSET	03/11/2025
2	N30.01	ACUTE CYSTITIS WITH HEMATURIA	ONSET	03/11/2025
3	B96.89	OTH BACTERIAL AGENTS AS THE CAUSE OF DISEASES CLASSD ELSWHR	ONSET	03/11/2025
4	I48.91	UNSPECIFIED ATRIAL FIBRILLATION	ONSET	03/11/2025
5	F03.90	UNSP DEMENTIA, UNSP SEVERITY, WITHOUT BEH/PSYCH/MOOD/ANX	ONSET	03/11/2025
6	I10	ESSENTIAL (PRIMARY) HYPERTENSION	ONSET	03/11/2025
7	E78.5	HYPERLIPIDEMIA, UNSPECIFIED	ONSET	03/11/2025
8	R33.9	RETENTION OF URINE, UNSPECIFIED	ONSET	03/11/2025
9	R32	UNSPECIFIED URINARY INCONTINENCE	ONSET	03/11/2025
10	Z79.82	LONG TERM (CURRENT) USE OF ASPIRIN	ONSET	03/11/2025
11	Z79.52	LONG TERM (CURRENT) USE OF SYSTEMIC STEROIDS	ONSET	03/11/2025
12	Z55.6	Problems related to health literacy	ONSET	03/11/2025

Frequency/Duration of Visits:
SN 2WK1,1WK2,1EVERY2WK6
PT EFFECTIVE 04/06/2025 1WK7

Orders of Discipline and Treatments:
SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE COUNTERSIGNED BY PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING INFLUENZA A, UTI, PNEUMONIA, EPIGASTRIC PAIN AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. NURSING ASSESSMENT TO BE PERFORMED BY RN: LPN TO OBSERVE AND REPORT CHANGES TO THE RN.

SKILLED NURSING TO PROVIDE SKILLED TEACHING TO MINIMIZE AND MANAGE IDENTIFIED RISKS OF HOSPITALIZATION AND/OR ED VISIT LISTED IN SUPPORTING DOCUMENTATION FOR RISK OF HOSPITAL READMISSION SECTION OF THE PLAN OF CARE.

SKILLED NURSE TO OBSERVE/ASSESS CARDIOVASCULAR SYSTEM, IDENTIFY CHANGES, AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO TEACH RELATED TO ALTERED CARDIOVASCULAR STATUS INCLUDING DISEASE PROCESS, NUTRITION/HYDRATION, MEDICATIONS, ACTIVITIES, AND PERSONAL/ENVIRONMENTAL FACTORS. REPORT OXYGEN SATURATION RESULTS LESS THAN 90% WITH REST OR 88% WITH EXERTIONAL ACTIVITIES AND OXYGENATION UNABLE TO RETURN TO BASELINE WITHIN 2 MINUTES OF REST. SIGNIFICANT CHANGES IN STATUS WILL BE REPORTED TO PHYSICIAN.

SKILLED NURSE TO OBSERVE/ASSESS PULMONARY SYSTEM, IDENTIFY CHANGES, AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO TEACH RELATED TO ALTERED PULMONARY STATUS INCLUDING DISEASE PROCESS, NUTRITION, MEDICATIONS, ACTIVITIES, AND PERSONAL/ENVIRONMENTAL FACTORS. REPORT OXYGEN SATURATION RESULTS LESS THAN 90% WITH REST OR 88% WITH EXERTIONAL ACTIVITIES AND OXYGENATION SATURATION UNABLE TO RETURN TO BASELINE WITHIN 2 MINUTES OF REST, WITH OR WITHOUT OXYGEN.

SKILLED NURSE TO OBSERVE/ASSESS GASTROINTESTINAL SYSTEM, IDENTIFY CHANGES, AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO TEACH RELATED TO ALTERED GASTROINTESTINAL STATUS INCLUDING DISEASE PROCESS, NUTRITION, MEDICATIONS, ACTIVITIES, AND PERSONAL/ENVIRONMENTAL FACTORS. SIGNIFICANT CHANGES IN STATUS WILL BE REPORTED TO PHYSICIAN.

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requires Home Health services on 03/22/2025.

Attending Physician's Signature and Date Signed

Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

Physician: Dr. Mistikawy, Hany A.

Clinician: Agency, Clinician

Signature: 

Date: 6/3/2025

Signature:

Date: 5/30/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	3/24/2025	3/24/2025 to 5/22/2025	A5300244927401	227260

Patient's Name	Provider's Name
BEATRICE P OLIVEIRA	FALL RIVER - CENTERWELL HOME HEALTH

Orders of Discipline and Treatments:

SKILLED NURSE TO OBSERVE/ASSESS GENITOURINARY SYSTEM, IDENTIFY CHANGES, AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO TEACH RELATED TO ALTERED GENITOURINARY STATUS INCLUDING DISEASE PROCESS, NUTRITION, MEDICATIONS, ACTIVITIES, AND PERSONAL/ENVIRONMENTAL FACTORS. SIGNIFICANT CHANGES IN CONDITION WILL BE REPORTED TO PHYSICIAN. OBTAIN URINE SPECIMEN VIA CLEAN CATCH AS INDICATED FOR SYMPTOMS OF UTI

SKILLED NURSE TO OBSERVE FOR FALL RISK, IDENTIFY CHANGES, AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO TEACH RELATED TO FALL RISK REDUCTION INCLUDING HOME/ENVIRONMENTAL SAFETY, MEDICATION MANAGEMENT, AND FALL PREVENTION.

PROVIDE TEACHING/REINFORCEMENT INFECTION CONTROL MEASURES.

SKILLED NURSE MAY PERFORM 3 PRN VISITS FOR SHORTNESS OF BREATH, COUGH, CONGESTION, FEVER, CHILLS, DIARRHEA, CONSTIPATION, SKIN CHANGES, PAIN, FALL

PHYSICAL THERAPY TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN.PHYSICAL THERAPY TO PROVIDE SKILLED TEACHING TO MINIMIZE AND MANAGE IDENTIFIED RISKS OF HOSPITALIZATION AND/OR ED VISIT LISTED IN SUPPORTING DOCUMENTATION FOR RISK OF HOSPITAL READMISSION SECTION OF THE PLAN OF CARE.PHYSICAL THERAPY TO PROVIDE THERAPEUTIC EXERCISE AND ACTIVITIES TO IMPROVE ROM/FUNCTIONAL FLEXIBILITY/STRENGTH AND POWERPHYSICAL THERAPY TO ESTABLISH/PROGRESS HOME EXERCISE PROGRAM.PHYSICAL THERAPY TO PROVIDE EDUCATION AND TRAINING TO PATIENT/CAREGIVER TO IMPROVE SAFETY WITH FUNCTIONAL MOBILITY AND TRANSFERS.PHYSICAL THERAPY TO PROVIDE FALL PREVENTION STRATEGIES TO REDUCE FALL RISK AND IMPROVE SAFETY WITH MOBILITY.PHYSICAL THERAPY TO PROVIDE GAIT TRAINING TO IMPROVE AMBULATION AND SAFETY WITHOUT ASSISTIVE DEVICE.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>101 PULSE<60>100 RESP<12>24 SYSTOLICBP<90>150 DIASTOLICBP<50>90 PAIN>7 O2SAT<90

Goals/Rehabilitation Potential/Discharge Plans:

A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS THE PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN.
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES ABILITY TO MANAGE THE RISK OF HOSPITALIZATION OR ED VISITS AS EVIDENCED BY NO HOSPITALIZATION OR ED VISITS DURING CARE.
CARDIOVASCULAR EXACERBATIONS ARE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS.
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES CARDIOVASCULAR DISEASE MANAGEMENT AS EVIDENCED BY DECREASED SYMPTOMS AND NO UNPLANNED HOSPITALIZATIONS BY 5/22/2025
PULMONARY EXACERBATIONS ARE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS. PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES PULMONARY DISEASE MANAGEMENT AS EVIDENCED BY IMPROVED ENDURANCE, DECREASED SHORTNESS OF BREATH, AND NO UNPLANNED HOSPITALIZATIONS BY 5/22/2025
GASTROINTESTINAL EXACERBATIONS ARE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS.
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES GASTROINTESTINAL DISEASE MANAGEMENT AS EVIDENCED BY DECREASED SYMPTOMS AND NO UNPLANNED HOSPITALIZATIONS BY 5/22/2025
GENITOURINARY EXACERBATIONS ARE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS. PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES GENITOURINARY DISEASE MANAGEMENT AS EVIDENCED BY DECREASED SYMPTOMS AND NO UNPLANNED HOSPITALIZATIONS BY 5/22/2025 .
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES FALL RISK REDUCTION AS EVIDENCED BY NO FALLS BY 5/22/2025
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES UNDERSTANDING OF INFECTION CONTROL MEASURES BY 5/22/2025
PRN VISITS WILL BE PERFORMED TIMELY AS INDICATED

A PHYSICAL THERAPY PLAN OF CARE WILL BE ORDERED BY PHYSICIAN AND PROVIDED BY PHYSICAL THERAPY. ALL GOALS TO BE MET BY END OF CURRENTLY APPROVED PLAN OF CARE.
PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES ABILITY TO MANAGE THE RISK OF HOSPITALIZATION OR ED VISITS AS EVIDENCED BY NO HOSPITALIZATION OR ED VISITS DURING CARE.
PATIENT WILL IMPROVE FUNCTION IN RESPONSE TO THERAPEUTIC EXERCISES AS EVIDENCED BY IMPROVED SAFETY AND INDEPENDENCE WITH ADLS AND MOBILITY BY 4/25/25
PATIENT WILL ADOPT AND INTEGRATE HOME EXERCISE PROGRAM INTO DAILY ROUTINE AS EVIDENCED BY PROGRESSION OF ACTIVITIES BY 4/25/25
PATIENT WILL IMPROVE FUNCTIONAL MOBILITY AND TRANSFERS AS EVIDENCED BY IMPROVED SAFETY AND INDEPENDENCE BY 4/25/25
PATIENT/CAREGIVER WILL IMPROVE AWARENESS OF FALL RISK FACTORS AND DEMONSTRATE APPROPRIATE ACTIONS TO REDUCE RISK FACTORS AS EVIDENCED BY IMPROVED SAFETY AND INDEPENDENCE WITH ADLS AND MOBILITY BY 4/25/25
PATIENT WILL IMPROVE GAIT TO OPTIMIZE SAFE HOME AMBULATION AS EVIDENCED BY IMPROVED SAFETY AND INDEPENDENCE WITH ADLS AND TUG SCORE IMPROVED TO 20 SEC BY 5/22/25

Rehab Potential:

GOOD/MARKED IMPROVEMENT IN FUNCTIONAL STATUS AS EXPECTED

DC Plans:

DC TO CAREGIVER UNDER SUPERVISION OF MD WHEN GOALS ARE MET

Signature of Physician	Date
Optional Name/Signature Of MICHELLE SILVA, RN / FLAVIA PEDRO RN, BD	Date 3/23/2025

Physician: Dr. Mistikawy, Hany A.

Signature: 

Date: 6/3/2025

Clinician: Agency, Clinician

Signature:

Date: 5/30/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
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Patient's Name	Provider's Name
BEATRICE P OLIVEIRA	FALL RIVER - CENTERWELL HOME HEALTH

DME and Supplies:
DME-SHOWER/TUB CHAIR/TRANSFER BENCH

Prognosis:
GOOD

Functional Limitations:
ENDURANCE; AMBULATION; BLADDER INCONTINENCE

Safety Measures:
BLEEDING PRECAUTIONS, CLEAR PATHWAYS, COGNITIVE IMPAIRMENT, EMERGENCY PLAN, ENDURANCE, FALL PREVENTION, UNIVERSAL PRECAUTIONS

Activities Permitted:
UP AS TOLERATED

Nutritional Requirements:
HEART HEALTHY/CARDIAC DIET

Advance Directives:
NONE

Mental Statuses:
FORGETFUL

Supporting Documentation for Cognitive Status:
(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.
2 - REQUIRES ASSISTANCE AND SOME DIRECTION IN SPECIFIC SITUATIONS (FOR EXAMPLE, ON ALL TASKS INVOLVING SHIFTING OF ATTENTION), OR CONSISTENTLY REQUIRES LOW STIMULUS ENVIRONMENT DUE TO DISTRACTIBILITY.
(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
3 - DURING THE DAY AND EVENING, BUT NOT CONSTANTLY
(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)
1 - MEMORY DEFICIT: FAILURE TO RECOGNIZE FAMILIAR PERSONS/PLACES, INABILITY TO RECALL EVENTS OF PAST 24 HOURS, SIGNIFICANT MEMORY LOSS SO THAT SUPERVISION IS REQUIRED || 2 - IMPAIRED DECISION-MAKING: FAILURE TO PERFORM USUAL ADLS OR IADLS, INABILITY TO APPROPRIATELY STOP ACTIVITIES, JEOPARDIZES SAFETY THROUGH ACTIONS

Supporting Documentation for Psychosocial Status:
(QM) (M1100B) PATIENT LIVES WITH OTHER PERSON(S) IN THE HOME: WHICH OF THE FOLLOWING BEST DESCRIBES THE PATIENT'S AVAILABILITY OF ASSISTANCE AT THEIR RESIDENCE?
09 - OCCASIONAL / SHORT-TERM ASSISTANCE

Supporting Documentation for Risk of Hospital Readmission:
(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)
5 - DECLINE IN MENTAL, EMOTIONAL, OR BEHAVIORAL STATUS IN THE PAST 3 MONTHS || 6 - REPORTED OR OBSERVED HISTORY OF DIFFICULTY COMPLYING WITH ANY MEDICAL INSTRUCTIONS (FOR EXAMPLE, MEDICATIONS, DIET, EXERCISE) IN THE PAST 3 MONTHS || 7 - CURRENTLY TAKING 5 OR MORE MEDICATIONS || 8 - CURRENTLY REPORTS EXHAUSTION || 9 - OTHER RISK(S) NOT LISTED IN 1 - 8
SPECIFY OTHER RISKS
COMORBIDITIES

Allergies:
AMLODIPINE ; AMOXICILLIN; AZITHROMYCIN; BENAZAPRIL; CEFPROZIL; CIPRO; METOPROLOL; METRONIDAZOLE; SULFAMETHOXAZOLE - TRIMETHOPRIM

Signature of Physician	Date
Optional Name/Signature Of MICHELLE SILVA, RN / FLAVIA PEDRO RN, BD	Date 3/23/2025

Physician: Dr. Mistikawy, Hany A.

Signature: 

Date: 6/3/2025

Clinician: Agency, Clinician

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Patient's Name	Provider's Name
BEATRICE P OLIVEIRA	FALL RIVER - CENTERWELL HOME HEALTH

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ASPIRIN 81 MG TABLET,DELAYED RELEASE		ORAL			
1 tablet	*DAILY*				
Reason: BLOOD THINNER Instructions: TAKE 1 TABLET DAILY					
ATENOLOL 50 MG TABLET		ORAL			
Per instructions	*TWICE EACH DAY*				
Reason: BLOOD PRESSURE Instructions: TAKE ONE TABLET BY MOUTH TWICE EACH DAY					
DILTIAZEM ER 120 MG CAPSULE,EXTENDED RELEASE 12 HR		ORAL			
2 capsule	*EVERY PM*				
Reason: HEART RATE CONTROL, BLOOD PRESSURE Instructions: TAKE 2 CAPSULES EVERY DINNER					
DONEPEZIL 10 MG TABLET		ORAL			
Per instructions	*ONCE DAILY*				
Reason: MEMORY Instructions: TAKE ONE TABLET BY MOUTH ONCE DAILY					
FENOFIBRATE 54 MG TABLET		ORAL			
Per instructions	*ONCE DAILY*				
Reason: CHOLESTEROL Instructions: TAKE 1 TABLET BY MOUTH ONCE DAILY FOR CHOLESTEROL REDUCTION					
HYDRALAZINE 25 MG TABLET		ORAL			
2 tablet	*3 TIMES DAILY*				
Reason: BLOOD PRESSURE Instructions: TAKE 2 TABLETS (TOTAL 50MG) 3X DAY					
LEVOTHYROXINE 50 MCG TABLET		ORAL			
Per instructions	*DAILY*				
Reason: THYROID Instructions: TAKE ONE TABLET BY MOUTH IN THE MORNING BEFORE BREAKFAST					
LISINOPRIL 10 MG TABLET		ORAL			Changed
1 tablet	*2 TIMES DAILY*				
Reason: BLOOD PRESSURE Instructions: TAKE 1 TABLET 2X DAY					
MULTIVITAMIN 50 PLUS TABLET		ORAL			
1 tablet	*DAILY*				
Reason: SUPPLEMENT Instructions: TAKE 1 TABLET DAILY					
ONDANSETRON HCL 4 MG TABLET		ORAL			
Per instructions	*AS NEEDED EVERY 8 HOURS/PRN*				
Reason: NAUSEA Instructions: TAKE 1 TABLET EVERY 8 HRS AS NEEDED FOR NAUSEA					
PANTOPRAZOLE 40 MG TABLET,DELAYED RELEASE		ORAL			
1 tablet	*DAILY*				
Reason: GI PAIN, NAUSEA Instructions: TAKE 1 TABLET EVERY AM					
PREDNISONE 1 MG TABLET		ORAL			
Per instructions	*EVERY*				
Reason: RHEUMATOID ARTHRITIS Instructions: TAKE 4 TABLETS EVERY MORNING WITH FOOD					
SUCRALFATE 100 MG/ML ORAL SUSPENSION		ORAL			New
10 mL	*4 TIMES DAILY*				
Reason: ACID REFLUX, HEALS GI ULCERS Instructions: TAKE 10ML 4X DAY					

Signature of Physician	Date
Optional Name/Signature Of MICHELLE SILVA, RN / FLAVIA PEDRO RN, BD	Date 3/23/2025

Physician: Dr. Mistikawy, Hany A.

Clinician: Agency, Clinician

Signature: 

Signature:

Date: 6/3/2025

Date: 5/30/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025

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Patient's Name	Provider's Name
BEATRICE P OLIVEIRA	FALL RIVER - CENTERWELL HOME HEALTH

Supporting Documentation for Home Health Eligibility:

CLINICAL SUMMARY (FOCUS: FOCUS OF CARE - PRINCIPLE DIAGNOSIS, OTHER PERTINENT DIAGNOSES, CLINICAL INFORMATION, UTILIZATION OF OTHER DISCIPLINES, SKILLED SERVICES PROVIDED):

SOC EVAL FOR A 77 Y/O FEMALE WHO WENT TO THE ER AT SAH 3/11 WITH WEAKNESS AND COUGH. SHE WAS ADMITTED WITH PNEUMONIA AND ACUTE CYSTITIS WITH HEMATURIA. SHE WAS TREATED WITH IV ANTIBIOTICS. HER SECOND DAY SHE TESTED POSITIVE FOR INFLUENZA A AND WAS TREATED WITH TAMIFLU. SHE THEN HAD EPIGASTRIC PAIN THOUGHT FROM ANTIBIOTICS AND POOR PO INTAKE. SHE WAS STARTED ON SUCRALFATE AND PANTOPRAZOLE. HER BP WAS ELEVATED AND SHE STARTED ON HYDRALAZINE AND DILTIAZEM WAS INCREASED. SHE IMPROVED AND DISCHARGED HOME 3/23.

SHE LIVES WITH HER SPOUSE IN A 2 LEVEL HOME. SHE AMBULATES WITHOUT A DEVICE AND SPOUSE ASSISTS WITH CARE.

SHE HAS A MEDICAL HISTORY OF DEMENTIA, HTN, AFIB AND HLD.

SHE WILL HAVE SN WITH FOCUS OF CARE DUE TO DEFICITS RELATED TO CYSTITIS WITH HEMATURIA, INFLUENZA A AND HTN

DISCUSSED PLAN OF CARE, PATIENT AGREEABLE, REVIEWED EMERGENCY PLAN, HOME FOLDER, CALL YOUR NURSE FLYER, NUMBER TO CONTACT MANAGER FLAVIA RN WITH COMPLAINTS OR CONCERNS, NUMBER FOR STATE COMPLIANT

THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE: (MARK ALL THAT APPLY)

PSYCHIATRIC SERVICES. REFUSAL OR INABILITY TO SAFELY LEAVE HOME UNATTENDED, USE OF SPECIAL TRANSPORTATION - LEVEL 1

DOES THE PATIENT MEET LEVEL 2 CRITERIA - NORMAL INABILITY TO LEAVE THE HOME EXISTS AND LEAVING HOME REQUIRES A CONSIDERABLE AND TAXING EFFORT?

YES

DESCRIBE THE PATIENT'S NORMAL INABILITY TO SAFELY LEAVE HOME INCLUDING ASSISTANCE REQUIRED AND IMPACT (SUCH AS EXACERBATION OF CONDITION) AND RECOVERY TIME NECESSARY WHEN PATIENT LEAVES THEIR HOME:

PATIENT REQUIRES ASSIST OF 1 TO SAFELY LEAVE HOME DUE TO DEMENTIA. SHE HAS DECREASED STRENGTH AND ENDURANCE AND IS A FALL RISK

Therapy Short Term/Long Term Goals:

Discipline: PT

TRANSFERS (PT)

SIT TO STAND (DISCHARGE FUNCTION SCORE)

STG: SETUP OR CLEAN-UP ASSISTANCE	LTG: INDEPENDENT
TARGET DATE: 4/25/2025	TARGET DATE: 5/22/2025

BALANCE AND FUNCTIONAL CAPACITY (PT)

SHORT PHYSICAL PERFORMANCE BATTERY (SPPB) (SUM SCORE)

STG: 3	LTG: 4
TARGET DATE: 4/25/2025	TARGET DATE: 5/22/2025

TIMED UP AND GO (TUG) (AVG SCORE IN SECONDS ROUNDED TO NEAREST WHOLE NUMBER)

STG: 25	LTG: 20
TARGET DATE: 4/25/2025	TARGET DATE: 5/22/2025

GAIT (ASSISTANCE) (PT)

LEVEL SURFACE ASSISTANCE

STG: SUPERVISION OR TOUCHING ASSISTANCE	LTG: SETUP OR CLEAN-UP ASSISTANCE
TARGET DATE: 4/25/2025	TARGET DATE: 5/22/2025

STAIRS ASSISTANCE

STG: SUPERVISION OR TOUCHING ASSISTANCE	LTG: SETUP OR CLEAN-UP ASSISTANCE
TARGET DATE: 4/25/2025	TARGET DATE: 5/22/2025

Signature of Physician	Date
Optional Name/Signature Of MICHELLE SILVA, RN / FLAVIA PEDRO RN, BD	Date 3/23/2025

Physician: Dr. Mistikawy, Hany A.

Clinician: Agency, Clinician

Signature: 

Signature:

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