

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order Number:

325645

Patient's Medicare No.	SOC Date 4/10/2025	Certification Period 4/10/2025 to 6/8/2025	Medical Record No. HH100005311201	Provider No. 417000
Patient's Name and Address: LOUISE MUZACA (401) 625-5233 140 NORTH COURT TIVERTON, RI 02878-		Provider's Name, Address and Telephone Number: VISITING NURSE HOME AND HOSPICE 438 EAST MAIN ROAD SUITE 100 MIDDLETOWN, RI 02842- F: (401) 293-0739 P: (401) 682-2100		
Physician's Name & Address: CHARLES CUMMINGS, MD 821 MAIN ROAD TIVERTON, RI 02878		P: (401)625-1001 F: (401)625-1584	Patient's Date of Birth: 7/31/1935 Patient's Gender: FEMALE Order Date: 4/10/2025 11:47 AM Verbal Order: Y Verbal Date: 4/10/2025 Verbal Time: 3:43 PM	
Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature) VICTORIA KIRBY, RN / KATHERINE SHERIFF RN 4/10/2025			Date HHA Received Signed POC	

Patient's Expressed Goals:
TO GET MY STRENGTH BACK

ICD-10

Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	I44.2	ATRIOVENTRICULAR BLOCK, COMPLETE	ONSET	04/10/2025
2	I48.0	PAROXYSMAL ATRIAL FIBRILLATION	EXACERBATION	04/10/2025
3	I13.0	HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	EXACERBATION	04/10/2025
4	I50.30	UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE	EXACERBATION	04/10/2025
5	N18.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED	EXACERBATION	04/10/2025
6	E66.01	MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES	EXACERBATION	04/10/2025
7	Z68.35	BODY MASS INDEX [BMI] 35.0-35.9, ADULT	EXACERBATION	04/10/2025
8	G40.909	EPILEPSY, UNSP, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS	EXACERBATION	04/10/2025
9	I71.40	ABDOMINAL AORTIC ANEURYSM, WITHOUT RUPTURE, UNSPECIFIED	EXACERBATION	04/10/2025
10	J96.01	ACUTE RESPIRATORY FAILURE WITH HYPOXIA	EXACERBATION	04/10/2025
11	J69.0	PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	EXACERBATION	04/10/2025
12	N17.9	ACUTE KIDNEY FAILURE, UNSPECIFIED	EXACERBATION	04/10/2025
13	D63.1	ANEMIA IN CHRONIC KIDNEY DISEASE	EXACERBATION	04/10/2025
14	E03.9	HYPOTHYROIDISM, UNSPECIFIED	EXACERBATION	04/10/2025
15	E78.5	HYPERLIPIDEMIA, UNSPECIFIED	EXACERBATION	04/10/2025
16	F41.9	ANXIETY DISORDER, UNSPECIFIED	EXACERBATION	04/10/2025
17	F32.A	DEPRESSION, UNSPECIFIED	EXACERBATION	04/10/2025
18	K21.9	GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS	EXACERBATION	04/10/2025
19	I25.10	ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS	EXACERBATION	04/10/2025
20	S42.291D	OTH DISP FX OF UPPER END R HUMER, SUBS FOR FX W ROUTN HEAL	EXACERBATION	04/10/2025
21	E83.51	HYPOCALCEMIA	EXACERBATION	04/10/2025
22	I16.0	HYPERTENSIVE URGENCY	EXACERBATION	04/10/2025
23	Z91.81	HISTORY OF FALLING	EXACERBATION	04/10/2025
24	Z95.0	PRESENCE OF CARDIAC PACEMAKER	EXACERBATION	04/10/2025
25	Z79.01	LONG TERM (CURRENT) USE OF ANTICOAGULANTS	EXACERBATION	04/10/2025

ICD-9

Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	V54.11	AFTERCARE HEALING TRAUMAT FX UP ARM	ONSET	04/08/2025

Frequency/Duration of Visits:

SN 1WK3

PT 1WK1

OT EFFECTIVE 04/13/2025 1WK1

MSW EFFECTIVE 04/13/2025 1WK1

HHA EFFECTIVE 04/13/2025 1WK2

VISITS MAY BE DISCONTINUED DUE TO DR APPOINTMENTS, REHOSPITALIZATION OR FOR PATIENT REFUSAL.

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.

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.

Patient's Medicare No.	SOC Date 4/10/2025	Certification Period 4/10/2025 to 6/8/2025	Medical Record No. HH100005311201	Provider No. 417000
Patient's Name LOUISE MUZACA			Provider's Name VISITING NURSE HOME AND HOSPICE	

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 AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS.

SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED CARDIOVASCULAR STATUS INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVELS PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS.

SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND CARE. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PHYSICIAN FOR EARLY INTERVENTION.

SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION.

SKILLED NURSE FOR MONITORING AND MANAGEMENT OF EFFECTIVENESS OF ANTICOAGULATION THERAPY REGIMEN AND SKILLED TEACHING RELATED TO ANTICOAGULATION MANAGEMENT. SKILLED NURSE TO INTERVENE WITH EFFECTIVE ANTICOAGULATION THERAPY.

PHYSICAL THERAPIST TO EVALUATE TO DETERMINE CONDITION, PHYSICAL THERAPY PLANS AND REHABILITATION POTENTIAL; EVALUATE HOME ENVIRONMENT TO ELIMINATE STRUCTURAL BARRIERS AND IMPROVE SAFETY TO INCREASE FUNCTIONAL INDEPENDENCE (RAMPS, ADAPTIVE WHEELCHAIR, BATHROOM AIDES) AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. THERAPIST MAY PERFORM O2 SATURATION LEVELS AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE.

OCCUPATIONAL THERAPIST TO EVALUATE FOR OT SERVICES AND DEVELOP PLAN OF CARE FOR PHYSICIAN SIGNATURE. OT TO DETERMINE CONDITION AND ABILITY TO PERFORM ADL'S AND IADL'S, ESTABLISHMENT OF A PLAN OF TREATMENT, REHABILITATION GOALS, AND EVALUATING THE HOME ENVIRONMENT FOR ACCESSIBILITY AND SAFETY AND RECOMMENDING MODIFICATION. THERAPIST MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE.

HOME HEALTH AIDE SERVICE FOR ASSISTANCE WITH PERSONAL CARE, HYGIENE AND ACTIVITIES OF DAILY LIVING.

MEDICAL SOCIAL SERVICES FOR EVALUATION TO ASSESS SOCIAL AND EMOTIONAL FACTORS RELATED TO THE PATIENT'S ILLNESS, NEED FOR CARE, RESPONSE TO TREATMENT, ADJUSTMENT TO CARE AND ASSIST WITH LONG RANGE PLANNING AND COMMUNITY RESOURCES TO BE FOLLOWED BY COLLABORATION WITH THE PHYSICIAN AND NURSE TO DEVELOP A PLAN OF CARE.

ADMISSION DATE: APRIL 10, 2025 REFERRED TO SERVICE FROM : DAWN HILL REHAB/S/P RIH FOCUS OF CARE FOR ADMISSION TO SERVICE: COMPLETE AV BLOCKS/P AV BLOCK, CARDIAC ARREST, PACEMAKER REPLACEMENT PATIENT WAS SCREENED BEFORE VISIT FOR COVID 19 SYMPTOMS. PATIENT NOT SHOWING ANY SIGNS OR SYMPTOMS OF VIRUS AT THIS TIME. PATIENT IS A 89 YEAR OLD FEMALE ADMITTED TO HOMECARE SERVICES. PAST MEDICAL HISTORY/COMORBIDITIES INCLUDE : CAD, CHF, OBESE, ANXIETY, DEPRESSION, COVID, ASPIRATION PNEUM, NOROVIRUS, AFIB, HYPOTHYROID, FX HUMERUS/FALLS, PACEMAKER, HTN, HLD, MACULAR DEGENERATION LEFT EYE ALL DX. CONFIRMED WITH MD VITAL SIGNS: 98.6, 64, 18, BP 142/72, SPO2 98% ON ROOM AIR. PRIOR LEVEL OF FUNCTIONAL ABILITY: ASSESSMENT FINDINGS: NEURO ALERT AND ORIENTED, FORGETFUL, EASILY DISTRACTED, ANXIOUS CARDIOPULMONARY HEART RATE REGULAR, LS DIM AND CTA, COLOR GOOD, PACEMAKER BATTERIES 2/21/25 INTEGUMENTARY/WOUNDS SKIN IS PALE, POOR TURGOR, INTACT GI DENIES N/V/D/C LAST BM 4/9/25 GU INCONTINENT OF URINE NUTRITION OBESE, PICKY EATER PER SON PAIN DENIES SHE HAS PAIN MOBILITY/ASSISTIVE DEVICE(S) RW, WC, COMMODE, SHOWER BENCH, ELEVATED TOILET SEAT SPECIFIC ASSESSMENT : PT CURRENTLY LIVING WITH SON AND 2 PETS IN ONE LEVEL HOME WITH STAIRS TO ENTER. SON IS RN WHO WORKS FROM HOME FOR INS COMPANIES. HE ADMIN ALL MEDICATIONS, PROVIDES FOOD AND CARE AT PRESENT, REQ INFO ON PCA PRIVATE PAY AND MSW JULIE WAS CONTACTED AND SHE WILL SEND INFO. SON STATES PT SLID TO FLOOR LAST NOC AND HE WAS NOT ABLE TO GET HER BACK IN SO CALLED RESCUE TO TRANSFER HER BACK TO BED, NO INJURIES. SHE IS INCONTINENT OF URINE AND REQ ASSIST TO BSC OR TOILET. DURING SNV I WASHED PT UP DUE TO URINE SOAKED CLOTHES. SON ASSISTED. PT WEARS BILAT LEG BRACES FOR AMB AND REQ ASSIST OF 1 AND RW. HAS WC IN HOME FOR ASSISTED MOBILITY. POTENTIAL BARRIERS: ANXIETY, DISTRACTION, PETS MEDICATIONS REVIEWED AND RECONCILED: RECONCILED MED LIST LOCATED ON POC, WITH SON WHO IS RN. PT IS TAKING AMIODARONE 200MG DAILY AND NURSING HOME BOWEL MEDS/ENEMA NOT IN HOME. SPOKE WITH PRIMARY MD AND REVIEWED POC. POC APPROVED UPCOMING APPOINTMENTS: APRIL 17 DR CUMMINGS...SON WILL TRY TO MAKE TELEVISIT. DISCHARGE PLAN: PT HAS STABLE C/P ASSESS DEMONSTRATED BY VS, EDEMA, NO SYNCOPAL EPISODES. MAY DISCHARGE FROM VISITING NURSE HOME AND HOSPICE FOR GOALS MET, NO FURTHER SKILLS, NO LONGER HOMEBOUND, PER CLIENT/PRIMARY CAREGIVER, MD REQUEST, UNSAFE HOME ENVIRONMENT, MOVED OUT OF SERVICE AREA, OR DISCHARGED TO HOSPICE SERVICE. MEDICATIONS REVIEWED AND RECONCILED. RECONCILED MEDICATION LIST LOCATED ON THE PLAN OF CARE. MAY DISCHARGE FROM VISITING NURSE HOME AND HOSPICE FOR GOALS MET, NO FURTHER SKILLS, NO LONGER HOMEBOUND, PER CLIENT/PRIMARY CAREGIVER, MD REQUEST, UNSAFE HOME ENVIRONMENT, MOVED OUT OF SERVICE AREA, OR DISCHARGED TO HOSPICE SERVICE.

Signature of Physician	Date
Optional Name/Signature Of VICTORIA KIRBY, RN / KATHERINE SHERIFF RN	Date 4/10/2025

Patient's Medicare No.	SOC Date 4/10/2025	Certification Period 4/10/2025 to 6/8/2025	Medical Record No. HH100005311201	Provider No. 417000
Patient's Name LOUISE MUZACA		Provider's Name VISITING NURSE HOME AND HOSPICE		

Orders of Discipline and Treatments:

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS IN BLOCK 23 ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 4/10/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>101
PULSE<50>100 RESP<12>28 SYSTOLICBP<90>150 DIASTOLICBP<50>90

Goals/Rehabilitation Potential/Discharge Plans:

A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS ALL PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN. GOAL TO BE ACHIEVED BY WEEK 1
CARDIOVASCULAR EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE ASSOCIATED RISK. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO CARE FOR ALTERED CARDIOVASCULAR STATUS BY END OF EPISODE. ABNORMAL O2 SATURATION LEVELS WILL BE REPORTED TO PHYSICIAN. GOAL TO BE ACHIEVED
CHANGES IN SKIN INTEGRITY STATUS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN FOR PROMPT INTERVENTION. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ADEQUATE KNOWLEDGE OF INTEGUMENTARY STATUS AND APPROPRIATE MEASURES TO PROMOTE SKIN INTEGRITY AND PREVENT INJURY. GOAL TO BE ACHIEVED
PATIENT WILL DEMONSTRATE/VERBALIZE KNOWLEDGE OF INTERVENTIONS TO PREVENT FALLS AND SAFETY HAZARDS. PATIENT WILL REMAIN SAFE WITHIN HOME ENVIRONMENT. GOAL TO BE ACHIEVED
INEFFECTIVE ANTICOAGULATION THERAPY WILL BE IDENTIFIED AND PROMPTLY REPORTED TO THE PHYSICIAN. PATIENT / CAREGIVER WILL VERBALIZE UNDERSTANDING OF PHARMACOLOGIC AND NON-PHARMACOLOGIC MEASURES TO MAINTAIN EFFECTIVE ANTICOAGULATION THERAPY. GOAL TO BE ACHIEVED BY WEEK 4
A PHYSICAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE TO INCREASE FUNCTIONAL INDEPENDENCE WILL BE ESTABLISHED FOR THE PHYSICIAN'S REVIEW AND SIGNATURE. GOAL TO BE ACHIEVED
AN OCCUPATIONAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S REHABILITATION POTENTIAL, AND ELIMINATION OF SAFETY HAZARDS TO INCREASE FUNCTIONAL INDEPENDENCE.
PATIENT WILL RECEIVE ASSISTANCE WITH PERSONAL CARE AND HYGIENE AND OTHER ACTIVITIES OF DAILY LIVING AS NEEDED. GOAL TO BE ACHIEVED
A MEDICAL SOCIAL SERVICES EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S SOCIAL AND EMOTIONAL FACTORS, NEED FOR CARE, RESPONSE TO TREATMENT AND ADJUSTMENT TO CARE, TO FOSTER INDEPENDENT LIVING AT HOME. GOAL TO BE ACHIEVED

Rehab Potential:

FAIR TO MEET GOALS BY END OF CERTIFICATION

DC Plans:

DC TO CARE OF FAMILY UNDER SUPERVISION OF MD WHEN GOALS ARE MET

DME and Supplies:

GAUZES / DRESSINGS; SPECIALTY DRESSINGS

Prognosis:

GUARDED

Functional Limitations:

BOWEL/BLADDER (INCONTINENCE); ENDURANCE; AMBULATION; ASSIST TO LEAVE HOME; ANTICOAGULATION; FALL RISK

Safety Measures:

ADEQUATE LIGHTING, ANTICOAGULATION PRECAUTIONS, BLEEDING PRECAUTIONS, CLEAR PATHWAYS, EMERGENCY PLAN, FALL PRECAUTIONS, PT ON ELIQUIS, UNIVERSAL PRECAUTIONS

Activities Permitted:

TRANSFER BED/CHAIR; EXERCISES PRESCRIBED; WHEELCHAIR; WALKER; FALL PRECAUTIONS; BLEEDING PRECAUTIONS

Nutritional Requirements:

REGULAR NO ADDED SALT

Advance Directives:

MED. PWR. OF ATTY

Mental Statuses:

ORIENTED; FORGETFUL

Allergies:

ADHESIVE TAPE; AZITHROMYCIN; DILTIAZEM; HONEY DEW MELON; LATEX; LEVOFLOXACIN; PCN

Signature of Physician	Date
Optional Name/Signature Of VICTORIA KIRBY, RN / KATHERINE SHERIFF RN	Date 4/10/2025

Patient's Medicare No.	SOC Date 4/10/2025	Certification Period 4/10/2025 to 6/8/2025	Medical Record No. HH100005311201	Provider No. 417000
Patient's Name LOUISE MUZACA			Provider's Name VISITING NURSE HOME AND HOSPICE	

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ACETAMINOPHEN 325 MG TABLET <i>2 tablet</i>	<i>EVERY 6 HOURS/PRN</i>	ORAL			
Reason: MILD PAIN OR FEVER					
Instructions: TAKE 2 TABLETS BY MOUTH EVERY 6 HOURS AS NEEDED FOR MILD PAIN 1-3/10 OR FEVER. NOT TO EXCEED 3G IN 24 HOURS.					
ALLERGY RELIEF (LORATADINE) 10 MG TABLET <i>1 tablet</i>	<i>DAILY/PRN</i>	ORAL			
Reason: FOR ALLERGIES					
Instructions:					
ALOPHEN (BISACODYL) 5 MG TABLET, DELAYED RELEASE <i>1 tablet</i>	<i>EVERY 72 HOURS/PRN</i>	ORAL			
Reason: FOR CONSTIPATION					
Instructions:					
AMIODARONE 200 MG TABLET <i>1 tablet</i>	<i>DAILY</i>	ORAL			New
Reason: CARDIAC					
Instructions:					
ARTHRITIS PAIN (DICLOFENAC) 1 % TOPICAL GEL <i>2 inch</i>	<i>2 TIMES DAILY/PRN</i>	TOPICAL			
Reason: MILD PAIN					
Instructions:					
ELIQUIS 5 MG TABLET <i>1 tablet</i>	<i>2 TIMES DAILY</i>	ORAL			
Reason: ANTICOAG					
Instructions:					
FUROSEMIDE 40 MG TABLET <i>1 tablet</i>	<i>DAILY</i>	ORAL			
Reason: FLUID					
Instructions: TAKE 1 TABLET (40 MG) IN AM AND 0.5 TABLET (20 MG) IN AFTERNOON FOR FLUID REMOVAL.					
LEVOTHYROXINE 137 MCG TABLET <i>1 tablet</i>	<i>DAILY</i>	ORAL			
Reason: THYROID					
Instructions:					
LISINAPRIL 20 MG TABLET <i>1 tablet</i>	<i>DAILY</i>	ORAL			
Reason: HTN					
Instructions:					
LOVASTATIN 40 MG TABLET <i>1 tablet</i>	<i>DAILY</i>	ORAL			
Reason: CHOLESTEROL					
Instructions:					
PANTOPRAZOLE 40 MG TABLET, DELAYED RELEASE <i>1 tablet</i>	<i>DAILY</i>	ORAL			
Reason: GERD					
Instructions:					
PRESERVISION AREDS 4,296 MCG-226 MG-90 MG CAPSULE <i>1 capsule</i>	<i>2 TIMES DAILY</i>	ORAL			
Reason: MAC DEG					
Instructions:					
SENNAPLUS 8.6 MG-50 MG TABLET <i>1 tablet</i>	<i>EVERY OTHER DAY/PRN</i>	ORAL			
Reason: CONSTIP					
Instructions:					

Signature of Physician	Date
Optional Name/Signature Of VICTORIA KIRBY, RN / KATHERINE SHERIFF RN	Date 4/10/2025

Patient's Medicare No.	SOC Date 4/10/2025	Certification Period 4/10/2025 to 6/8/2025	Medical Record No. HH100005311201	Provider No. 417000
Patient's Name LOUISE MUZACA		Provider's Name VISITING NURSE HOME AND HOSPICE		

Supporting Documentation for Home Health Eligibility:

THE PATIENT IS HOMEBOUND BECAUSE OF THESE ENVIRONMENTAL AND/OR PHYSICAL CONDITIONS:

INCREASED WEAKNESS, FATIGUE, GAIT DEFICIT, HIGH FALL RISK, POOR ENDURANCE

IMPAIRED BODY FUNCTIONS/STRUCTURES THAT REQUIRE HOME HEALTH INTERVENTION AND IMPACT THE PATIENT'S ABILITY TO LEAVE THE HOME SAFELY:

FALL RISK, GAIT DEFICIT, UNSTEADY GAIT/DECREASED BALANCE

THE FOLLOWING SKILLED DISCIPLINES ARE REASONABLE AND NECESSARY AT THIS TIME:

OCCUPATIONAL THERAPY, PHYSICAL THERAPY, SKILLED NURSING

DUE TO ILLNESS OR INJURY, THE PATIENT IS RESTRICTED FROM LEAVING HOME EXCEPT WITH:

THE AID OF SUPPORTIVE DEVICES SUCH AS CRUTCHES, WHEELCHAIRS, OR WALKERS, THE ASSISTANCE OF ANOTHER PERSON

DOES THE PATIENT HAVE A NORMAL INABILITY TO LEAVE HOME SUCH THAT LEAVING HOME REQUIRES CONSIDERABLE AND TAXING EFFORT?

YES

Signature of Physician	Date
Optional Name/Signature Of VICTORIA KIRBY, RN / KATHERINE SHERIFF RN	Date 4/10/2025