CHI Health at Home
VNA Health at Home

VNA Health at Home – Home Care
2464 Fortune Drive, Suite 110
Lexington, KY 40509
P: 859-277-5111 F: 859-278-0597

Fax Lead Sheet

DATE: 7/16/25

ATTENTION: _____

COMPANY: MS Graft Wound

FAX NO: 859-399-6697

PHONE NO: _____

RE: _____

MESSAGE:

NUMBER OF PAGES: _____ (Including Lead Sheet)

FROM: VNA HEALTH AT HOME

PHONE NO: 859-277-5111

THANK YOU!

RETURN FAX NUMBER: 859-278-0597 or 888-218-1137

Order Number: 6096073

Printed: 7/16/2025 4:59 PM
Eastern Time Zone

VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT
2464 FORTUNE DRIVE SUITE 110
LEXINGTON, KY 40509-4254
Phone: (859) 277-5111
Fax: (859) 317-2507

PHYSICIAN:

ERIN BUTLER, PA
3470 BLAZER PKWY
LEXINGTON, KY 40509-

Phone: (859)629-7110
Fax: (859)543-1989
2nd Physician:
Send to Physician: Y
Verbal Order: Y
Verbal Date: 7/15/2025 Time: 2:23 PM

CLIENT:

ROSE, IRRIVILLA
1038 BURNELL DR
BEREA, KY 40403-

SSN: XXX-XX-
DOB: 4/26/1941 MR#: 04200077200401
CERT: 6/26/2025 to 8/24/2025
Order Read Back to Physician/Agent of Physician?: Y
ABN Delivered to Patient?: NA

Order Date: 7/15/2025 2:23 PM Order Type: PHYSICIAN ORDER

Order Description:
VO TORY/ ERIN BUTLER.
SEND WOUND CARE REFERRAL TO MCGRATH WOUND CARE.
MAY TAKE ORDERS FROM DR. MOHAMMED ATHAR

ENTERED / TAKEN BY (ELECTRONICALLY SIGNED): SHARITA MEADOWS, RN DATE: 07/15/2025

APPROVED / PROCESSED BY (ELECTRONICALLY SIGNED): DATE:

PHYSICIAN SIGNATURE: DATE:

Order Number:
6061381

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	6/26/2025	6/26/2025 to 8/24/2025	04200077200401	187113

Patient's Name and Address:
IRRIVILLA ROSE (859) 985-0671
1038 BURNELL DR
BEREA, KY 40403-

Provider's Name, Address and Telephone Number:
VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT F: (859) 317-2507
2464 FORTUNE DRIVE SUITE 110
LEXINGTON, KY 40509- P: (859) 277-5111

Physician's Name & Address: P: (859)629-7110 F: (859)543-1989

ERIN BUTLER, PA
3470 BLAZER PKWY
LEXINGTON, KY 40509-

Patient's Date of Birth: 4/26/1941
Patient's Gender: FEMALE
Order Date: 6/26/2025 10:59 AM
Verbal Order: N

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)	Date HHA Received Signed POC
LELIA FRITZ, RN 6/24/2025	

Patient's Expressed Goals:
FEEL BETTER AND BE ABLE GET OUT AND DRIVE.

ICD-10 Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	Z48.3	AFTERCARE FOLLOWING SURGERY FOR NEOPLASM	EXACERBATION	06/26/2025
2	C50.312	MALIG NEOPLASM OF LOWER-INNER QUADRANT OF LEFT FEMALE BREAST	EXACERBATION	06/26/2025
3	J18.9	PNEUMONIA, UNSPECIFIED ORGANISM	EXACERBATION	06/26/2025
4	E03.9	HYPOTHYROIDISM, UNSPECIFIED	EXACERBATION	06/26/2025
5	I10	ESSENTIAL (PRIMARY) HYPERTENSION	EXACERBATION	06/26/2025
6	Z60.4	SOCIAL EXCLUSION AND REJECTION	EXACERBATION	06/26/2025
7	Z55.6	Problems related to health literacy	EXACERBATION	06/26/2025
8	Z90.710	ACQUIRED ABSENCE OF BOTH CERVIX AND UTERUS	EXACERBATION	06/26/2025
9	Z91.81	HISTORY OF FALLING	EXACERBATION	06/26/2025

Frequency/Duration of Visits:
SN 1WK4,4WK1,1WK4

Orders of Discipline and Treatments:
THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS BELOW ATTESTS THAT THESE ORDERS WERE RECEIVED ON CALLED TODAY WILL CGECK 6/27/25

SKILLED NURSE TO PROVIDE SKILLED TEACHING TO PATIENT/CAREGIVER OF HYPERTENSION TO INCLUDE MEDICATION MANAGEMENT, SELF-ASSESSMENT, LOW SODIUM DIET, AND TRACKING OF BLOOD PRESSURE RESULTS.

SKILLED NURSE TO OBSERVE AND ASSESS PATIENT WITH GENERALIZED DEPRESSION. ASSESS NEED FOR MEDICATION, MEDICATION CHANGES AND POTENTIAL NEED FOR REFERRAL TO PROVIDE COUNSELING AND ASSISTANCE WITH MANAGING DEPRESSION.

SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT INCLUDING MEDICATION REVIEW AND PHARMACOLOGICAL AND NONPHARMACOLOGICAL TREATMENTS AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. SKILLED NURSE TO INTERVENE WITH INCREASED PAIN LEVEL TO MINIMIZE COMPLICATIONS.

SKILLED NURSE TO FOCUS ON IDENTIFIED NEED FOR HIGH RISK MEDICATION INTERVENTION.

SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO AREA UNDER LEFT BREAST. CLEANSE WITH SALINE OR SOAP AND WATER APPLY. COVER WITH BORDER DRESSING. WOUND CARE TO BE PERFORMED EVERY 2-3 DAYS AND PRN SOILD DRESSING. .

SKILLED NURSE PRN VISIT ORDER: 3 PRN VISITS MAY BE PERFORMED DURING THIS CERTIFICATION PERIOD FOR THE FOLLOWING REASON (S): WOUND CARE, RESPIRATORY FAILURE, MALNUTRITION. SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE ANY CONDITIONS THAT PRESENT THEMSELVES AND THAT WILL IMPACT THE PLAN OF CARE DURING THE COURSE OF THE EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. TEACH AND MONITOR PATIENT/CAREGIVER ABILITY TO SAFELY ADMINISTER MEDICATIONS. PHONE TOUCHPOINTS CAN BE PERFORMED AS NEEDED TO SUPPLEMENT THE PLAN OF CARE.

PATIENT/CAREGIVER NIECE WILL BE KNOWLEDGEABLE OF DISCHARGE PLANS AND WILL DEMONSTRATE/PROVIDE EDUCATION AND RESOURCES NEEDED TO MAINTAIN HEALTH.

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 therepy. 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 06/09/2025.

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.

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	6/26/2025	6/26/2025 to 8/24/2025	04200077200401	187113

Patient's Name	Provider's Name
IRRIVILLA ROSE	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT

Orders of Discipline and Treatments:

AGENCY WILL DISCHARGE PATIENT TO DR DONNY HARDY PHYSICIAN/HEALTH CARE PROVIDER AND MAY ACCEPT ORDERS FROM THE FOLLOWING PHYSICIANS: ERIN BUTLER PA, ONCOLOGIST DR NICOLA JABBOUR, DR. MOHAMMED ATHAR

CLINICIAN TO OBSERVE AND ASSESS PATIENT WITH DEMENTIA OR OTHER RELATED CONDITION AND INSTRUCT FAMILY/CAREGIVERS IN HEALTHY COPING TECHNIQUES AND STRATEGIES.

CLINICIAN TO EDUCATE PATIENT / CAREGIVER IN FALL PREVENTION AND PROVIDE INTERVENTIONS TO REDUCE FALL RISK AND ENHANCE HOME SAFETY

PSYCHOSOCIAL / COGNITIVE ASSESSMENT INDICATES NO NEED FOR SOCIAL, FINANCIAL, OR TRANSPORTATION SUPPORT OR FOR ADDITIONAL CARE PROVIDERS/DISCIPLINES OR REFERRALS TO OUTSIDE ENTITIES.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS PLAN OF CARE ATTESTS THAT THE COMPREHENSIVE ASSESSMENT FINDINGS WERE DISCUSSED AND ORDERS WERE RECEIVED AS INDICATED BY THE VERBAL ORDER DATE AND TIME 6/26/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>101.1 PULSE<50>100 RESP<12>25 SYSTOLICBP<90>160 DIASTOLICBP<50>100 PAIN>9 O2SAT<88

Goals/Rehabilitation Potential/Discharge Plans:

PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO CARE FOR HYPERTENSION. GOAL TO BE MET BY 9/25/25
PATIENT/CAREGIVER NIECE WILL VERBALIZE MEASURES TO COPE WITH DEPRESSION AND STATE SIGNS AND SYMPTOMS TO REPORT TO PHYSICIAN BY 8/21/25
INCREASED PAIN OR PAIN CONTROL MEASURES WILL BE IDENTIFIED AND PROMPTLY REPORTED TO THE PHYSICIAN. PATIENT / CAREGIVER WILL VERBALIZE UNDERSTANDING OF PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN CONTROL MEASURES. GOAL TO BE MET BY 9/25/25
PATIENT/CAREGIVER DEMONSTRATES ABILITY TO ADHERE TO MEDICATION REGIMEN. GOAL TO BE MET BY7/29/25
PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO PERFORM WOUND CARE. WOUND STATUS WILL IMPROVE AS EVIDENCED BY A DECREASE IN SIZE, DRAINAGE, ABSENCE OF INFECTION, AND DECREASED PAIN. GOAL TO BE MET BY 8/21/25
A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS ALL PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN.
PATIENT AND/OR CAREGIVER WILL BE IN AGREEMENT WITH DISCHARGE PLANS AND WILL VERBALIZE HAVING RESOURCES AND KNOWLEDGE TO MAINTAIN HEALTH.
PATIENT WILL REMAIN SAFE AND NEEDS WILL BE MET BY COLLABORATING ON POC AND COMMUNICATING CHANGES IN POC AND CHANGES AFFECTING DISCHARGE PLAN WITH PATIENT, CAREGIVER, RECEIVING PHYSICIAN/HEALTH CARE PROVIDER, AND OTHER PHYSICIANS WRITING ORDERS ON THE POC THROUGHOUT CERTIFICATION PERIOD.
FAMILY/CAREGIVERS NIEDE WILL VERBALIZE AND DEMONSTRATION HEALTHY COPING TECHNIQUES AND STRATEGIES TO MANAGE CARE FOR THE PATIENT WITH DEMENTIA OR OTHER RELATED CONDITION. GOAL TO BE MET BY 8/21/25
PATIENT TO DEMONSTRATE REDUCED FALL RISK AND IMPROVE HOME SAFETY BY 8/21/25
PATIENT/CAREGIVER VERBALIZES AND DEMONSTRATES ABILITY FOR THE PATIENT TO FUNCTION WITHIN THEIR COMMUNITY AND TO PARTICIPATE IN THE DEVELOPMENT AND IMPLEMENTATION OF THEIR CARE PLAN THROUGHOUT THE CERTIFICATION PERIOD.

Rehab Potential:

FAIR/IMPROVEMENT IN STATUS IS UNCERTAIN

DC Plans:

DISCHARGE TO CARE OF CAREGIVER UNDER SUPERVISION OF PHYSICIAN WHEN GOALS ARE MET

DME and Supplies:

DME-AID-GRAB BARS SHOWER/TUB; DME-AID-GRAB BARS TOILET; DME-RAILS/GRAB BARS; GLOVES ; SOLUTION/SKIN PREP; WOUND CARE

Prognosis:

FAIR

Functional Limitations:

ENDURANCE; AMBULATION; ASSIST TO LEAVE HOME; ASSIST X 1 PERSON; ASSIST WITH TRANSFERS

Safety Measures:

EMERGENCY PLAN, FALL PREVENTION, FIRE RESPONSE PLAN, HIGH RISK FOR FALLS, UNIVERSAL PRECAUTIONS

Activities Permitted:

UP AS TOLERATED; WALKER; ASSIST W/ALL ACTIVITIES; ASSIST X 1; WOUND; ASSIST WITH BATHING

Nutritional Requirements:

REGULAR DIET

Advance Directives:

DO NOT RESUSCITATE

Signature of Physician	Date
Optional Name/Signature Of LELIA FRITZ, RN	Date 6/24/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	6/26/2025	6/26/2025 to 8/24/2025	04200077200401	187113

Patient's Name	Provider's Name
IRRIVILLA ROSE	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT

Mental Statuses:
ORIENTED; FORGETFUL; ALERT; ORIENTED TO TIME; ORIENTED TO PLACE; ORIENTED TO PERSON

Supporting Documentation for Cognitive Status:
(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
1 - IN NEW OR COMPLEX SITUATIONS ONLY
(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)
7 - NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

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.)
2 - UNINTENTIONAL WEIGHT LOSS OF A TOTAL OF 10 POUNDS OR MORE IN THE PAST 12 MONTHS || 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

Allergies:
ASPIRIN

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
LETROZOLE 2.5 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: CHEMO BREAST CA Instructions:					
LEVOTHYROXINE 50 MCG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: HYPOTHYROIDISM Instructions:					
METOPROLOL TARTRATE 25 MG TABLET		ORAL			
1 tablet	*2 TIMES DAILY*				
Reason: HT RATE Instructions:					
POTASSIUM CHLORIDE ER 20 MEQ TABLET,EXTENDED RELEASE		ORAL			
1 tablet	*DAILY*				
Reason: SUPPLEMENT Instructions:					
VITAMIN B-12 1,000 MCG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: SUPPLEMENT Instructions:					

Supporting Documentation for Home Health Eligibility:
ACTIVITY LIMITATIONS: SKILLED SERVICES, LISTED IN FIELD 21 OF PLAN OF CARE ORDER, ARE NEEDED IN THE FOLLOWING MANNER:
MOBILITY/WELLNESS AND EXERCISE, SELF-CARE OF HEALTH CONDITIONS/MEDICATION MANAGEMENT

STRUCTURAL AND FUNCTIONAL LIMITATIONS: IMPAIRED BODY FUNCTIONS THAT EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE PLAN OF CARE:
FUNCTIONS OF THE DIGESTIVE SYSTEM (F), SKIN AND RELATED STRUCTURES (S), STRUCTURES OF THE RESPIRATORY SYSTEM (S)

THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE: (MARK ALL THAT APPLY)
ASSISTANCE OF ANOTHER PERSON IN ORDER TO LEAVE PLACE OF RESIDENCE, USE OF SPECIAL TRANSPORTATION

THE PATIENT HAS NORMAL INABILITY TO LEAVE THE HOME AND LEAVING THE HOME TAKES CONSIDERABLE AND TAXING EFFORT BECAUSE:

FALL RISK, GAIT DEFICIT

Signature of Physician	Date
Optional Name/Signature Of LELIA FRITZ, RN	Date 6/24/2025

07/16/2025 05:01:51 PM
Printed By: MEADOWS, SHARITA L

Patient Information Report

Patient:	ROSE, IRRIVILLA	**Insured ID:**	H63065711	**Primary Payor:**	HUMANA MCR ADV PDGM
MR No:	04200077200401				
Legacy MR No:					

Assigned Branch	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGTON	**Assigned Team**	TEAM B	**Location**	
Patient Nickname		**Patient ID**	772004	**SSN**	XXX-XX-

Referral Info

Referral Date	06/24/2025	**Referral Type**	READMISSION	**Referral Taken By**	INTERFACE
Referral Source		**Referring Physician**		**Referring Physician Contact**	
PHYSICIAN		BUTLER, ERIN		ERIN BUTLER	

Care Type and Effective Date (* = Primary)

HOME HEALTH 06/26/2025 - (P)
RSP2 06/26/2025 -
CARELINK - SKIN AND WOUND 06/26/2025 -

Demographic

Patient Info

Gender	FEMALE	**DOB**	04/26/1941	**Race**	
Preferred Language					
Primary Phone	8597791201	**Alt Phone**		**Email**	

Primary Address

Street			**City**	**State**	**Zip**	**County**
1038 BURNELL DR			BEREA	KY	40403-	MADISON
Phone	**MSA #**	**CBSA**		**Floor**		**Room**
(859)779-1201		99918				
Travel Directions						

Current Service Location: CLIENT'S HOME/RESIDENCE

Street			**City**	**State**	**Zip**	**County**
1038 BURNELL DR			BEREA	KY	40403-	MADISON
Phone	**MSA #**	**CBSA**		**Floor**		**Room**
(859) 779-1201		99918				
Travel Directions						

Patient Contacts

Contact Name	**Relationship**	**Contact Type**	**Contact Relationship Type**
ROBIN ANGEL	NIECE	EMERGENCY CONTACT	PRIMARY CAREGIVER
Home Phone	**Primary Phone**	**Alternate Phone**	**Address**
	(859) 779-1201		1180 SAM BROWNING RD, LEBANON, KY, 40033

Contact Name	**Relationship**	**Contact Type**	**Contact Relationship Type**
SANDY JOHNSON	NIECE	OTHER CONTACT	
Home Phone	**Primary Phone**	**Alternate Phone**	**Address**
	(606) 493-7195		MCKEE, KY

Payor Source Info

Payor Source Type	**Payor Type**	**Payor Source**	**Is patient in an HMO (HHCAHPS)?**
PRIMARY	MANAGED MEDICARE PPS / PDGM	HUMANA MCR ADV PDGM	N
Medicare No.	**Medicare A Effective**	**Medicare B Effective**	**Admission Source**
			1 - PHYSICIAN REFERRAL
Medicaid No.	**Medicaid Effective**	**Physician Medicaid No.**	**Physician Name**
			BUTLER, ERIN

Private Payor Type Info

Patient Information Report

Patient: ROSE, IRRIVILLA **Insured ID:** H63065711 **Primary Payor:** HUMANA MCR ADV PDGM
MR No: 04200077200401
Legacy MR No:

Claim No.	Policy No.	Insured ID
	H63065711	

Insured Name **Insured Relation** **Insured Address**

Insured City **Insured State** **Insured Zip**

Insured Phone

Employer Name **Employer ID** **Employer Address**

Employer City **Employer State** **Employer Zip**

Employer Phone

Program Name	Obtained Date	Obtained By/ Authorized By	Authorization No./ Active	Start Date/ End Date
PPS PROGRAM	6/27/2025 12:24:25 PM	PAMELA THOMAS, Brittany	211397499 Y	06/26/2025 08/24/2025

Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
VISITS	DISCIPLINES	HHA	60					Y
VISITS	DISCIPLINES	MSW	60					Y
VISITS	DISCIPLINES	OT	60					Y
VISITS	DISCIPLINES	PT	60					Y
VISITS	DISCIPLINES	SN	60					Y
VISITS	DISCIPLINES	ST	60					Y

Physician Info

Primary Physician **NPI #** **Date Last Seen**
BUTLER, ERIN 1194141127

Address **City** **State** **Zip**
3470 BLAZER PKWY LEXINGTON KY 40509-

Phone **Fax** **Pager**
(859)629-7110 (859)543-1989

Secondary Physician
HARDY, DONNY

Perform Add-On Evalution Prior to Approval of the Plan of Care associated with the Completed SOC Visit?
N

Requested Date of Evaluation **Admitting Discipline**
06/26/2025 SN

Requested Date of Add-On Evaluation **Add-On Discipline**

Clinical Info

Case Manager
JAN RUGEBREGT, RN

Team Member(s)
BRAUN APPLEGATE, PT
JOHN LEAR-PHILLIPS, OT
LELIA FRITZ, RN
TAMMY CLAYWELL, PTA

Weight	Height	Pregnant	Paperwork Received By Patient
		Y	Y

Medical Release Code

Patient Information Report

Patient: ROSE, IRRIVILLA **Insured ID:** H63065711 **Primary Payor:** HUMANA MCR ADV PDGM
MR No: 04200077200401
Legacy MR No:

YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATED TO A CLAIM

Acuity Status	Disaster Status	Evacuation Location
3 - WITHIN WEEK	AMBULATORY	NIECE HOME

Type	Location	Contents	Contact Name	Contact Phone	Was Adv Dir Info Left With Caregiver?
DO NOT RESUSCITATE	NIECE HAS THEM				N

Home Health Care Survey

Is care related to surgical discharge?	Does patient have end-stage renal disease?	Number of ADLs for which patient is not independent?

Has patient requested "No Publicity" status?	Is maternity care the primary reason for home health care?	Primary Spoken Language
N	N	

ICD-10 Diagnoses/Procedures

Order	Code	Description	Onset / Exac.	O/E Date	Type	Sym. Ctrl. Rtg.	OASIS Item
1	Z48.3	AFTERCARE FOLLOWING SURGERY FOR NEOPLASM	E	06/26/2025	D		M1021
2	C50.312	MALIG NEOPLASM OF LOWER-INNER QUADRANT OF LEFT FEMALE BREAST	E	06/26/2025	D	1 - Symptoms well controlled with current therapy.	M1023
3	J18.9	PNEUMONIA, UNSPECIFIED ORGANISM	E	06/26/2025	D	1 - Symptoms well controlled with current therapy.	M1023
4	E03.9	HYPOTHYROIDISM, UNSPECIFIED	E	06/26/2025	D	1 - Symptoms well controlled with current therapy.	M1023
5	I10	ESSENTIAL (PRIMARY) HYPERTENSION	E	06/26/2025	D	1 - Symptoms well controlled with current therapy.	M1023
6	Z60.4	SOCIAL EXCLUSION AND REJECTION	E	06/26/2025	D		M1023
7	Z55.6	Problems related to health literacy	E	06/26/2025	D		M1023
8	Z90.710	ACQUIRED ABSENCE OF BOTH CERVIX AND UTERUS	E	06/26/2025	D		M1023
9	Z91.81	HISTORY OF FALLING	E	06/26/2025	D		M1023

Allergies

Description	Date Entered
ASPIRIN	6/26/2025 12:04:32 PM

* denotes Non-Visit QI Reporting Collection