

X *Paul Fortaleza*

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**GAMA Physical Therapy**  
**PROMINENT HOME HEALTH CARE**  
**PHYSICIAN ORDERS**

X *Paul Fortaleza*

Patient Name	Medical Records #	Attending Physician
DERVISHIAN, OGANES	66	FORTALEZA, PAUL

**PATIENT'S STATUS/FINDINGS**

Patient has improved in all aspects of PT treatments. Decrease of pain in LB/BUE/BLE 0-2/10, decrease joint swelling/joint stiffness/joint pain increased ROM in BLE/BUE/LB, able to continue HEP with assistance of family/CG. Patient has positively managed them self towards established goals: Gait with SPC increased bed mobility and transfers. Enhanced endurance, safety, balance to G.

**PHYSICIAN ORDERS**

**PHYSICAL THERAPY:**

Discharge patient from home Physical Therapy services, goals are met.

Order read back and verified

**Orders Taken By:**

KRIMSON ENVERGA ,	RPT	Date: 10/13/2019
Signature: <i>Krimson</i>		
Physician's Signature:		Date: / /



**GAMA Physical Therapy**  
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**PATIENT'S STATUS/FINDINGS**

Patient C/O pain in LB/BLE/BUE 5/10, increased joint pain/joint swelling, decreased ROM in BLE/BUE/LB. These directly impact overall ability to ambulate, limit ADL's, and provide unsteady movement. Patient requires assistance with bed mobility, transfer, safety, balance and all other actions performed. Patient will benefit from skilled PT services by improving self-functional level and capability of completing activities.

**Frequency: 1w1 3w3 1w1**

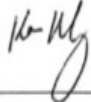
**PHYSICIAN ORDERS**



**PHYSICAL THERAPY: Evaluation**

1. Therapeutic exercises for BLE/LB.
2. Balance and coordination exercises when standing/sitting.
3. Bed mobility and transfer with body mech. and hand placement cues;
4. Pre-Gait with balance and postural cues and safety training.
5. HEP training, muscle reeducation and safety training with family/CG.
6. Endurance training, proper use of DME if needed.
7. Pre-Gait training on level surfaces with coming to stand activities.
8. Gait training with or w/o AD on level and uneven surfaces safely.

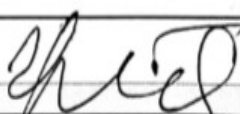
**Orders Taken By**

KRIMSON ENVERGA,	RPT	Date: 09/19/2019
Signature: 		
Physician's Signature:		Date: / /

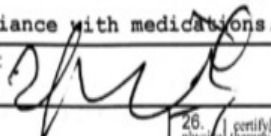
# PROMINENT HOME HEALTH CARE, INC.

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## Home Health Services Request

PATIENT INFORMATION	DERVISHIAN OGANES		11/11/36	<input checked="" type="checkbox"/> Male	
	<i>Patient Name: Last, First, Middle</i>		<i>Date of Birth</i>	<input type="checkbox"/> Female	<i>Religion</i>
	15044 MAGNOLIA BLVD. #11 SHERMAN OAKS CA 91403			(818) 481-6610	
	<i>Address - Street, Apt., City, County, State</i>			<i>Telephone number</i>	
	09/17/19	09/18/19	GARRY(SON)	(818) 481-6011	
	<i>Referral Date</i>	<i>SOC Date</i>	<i>Primary Contact, Relationship</i>	<i>Telephone number</i>	
	548433916M				
	<i>Medicare Number</i>	<i>Medicaid or DSS ID Number</i>	<i>Other Insurance Carrier</i>	<i>Policy or Claim Number</i>	
	DIAGNOSIS	Chronic pain syndrome			
<i>Primary Diagnosis</i>		<i>Hospitalization</i>		<i>From</i>	<i>To</i>
Polyarthralgia, unspecified, Hypertensive heart disease without heart failure, Type 2 diabetes mellitus with diabetic neuropathy, unsp, Alzheimer's disease with late onset, Dementia in cft diseases classed elsewhere w/o behavioral disturb, Major depressive disorder, single episode, mild, Long					
<i>Secondary Diagnosis</i>					
NO KNOWN ALLERGIES					
PHYSICIAN'S ORDER	<i>Surgery and Dates</i>				
	<i>Allergy</i>				
	Please assess patient for possible admission to Home Health Care. Skilled Nurse to assess, teach and provide nursing intervention.				
	<i>Treatments, Medications, Activity Permitted</i>				
	SN Frequency : 2W2; 1W7;		<input checked="" type="checkbox"/> Skilled Nursing	<input checked="" type="checkbox"/> Physical Therapy	
	HHA Frequency		<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	
			<input type="checkbox"/> Medical Social Worker	<input type="checkbox"/> Home Health Aide	
	Diet NAS, LOW FAT/CHOLESTEROL, CONTROLLED CARBOHYDRATE DIET				
	FORTALEZA, PAUL		(818) 325-2090	(818) 325-2092	
	<i>Attending Physician's Name</i>		<i>Telephone number</i>	<i>Fax number</i>	
		6350 LAUREL CANYON BLVD. #205 NORTH HOLLYWOOD CA 91606			
<i>Physician's Signature</i>		<i>Physician's Address</i>		<i>UPIN</i>	
NURSING	NON STERILE GLOVES, ALCOHOL SWABS, DIABETIC SUPPLIES (GLUCOMETER, SYRINGES, CHAMSTRIPS, LANCETS, SHARPS CONTAINER), UNDERPADS, BATHBENCH, CANE.				
	<i>Supplies, Equipment Needed (Specify Items), DME</i>				
SILVA MEKSEREJIAN(Orders read back/confirmed)				09/17/19	
<i>Referral Taken By</i>				<i>Date</i>	

## HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. <b>548433916M</b>		2. Start Of Care Date <b>09/18/2019</b>		3. Certification Period <b>09/18/2019 - 11/16/2019</b>		4. Medical Record No. <b>000000066-001</b>		5. Provider No. <b>553133</b>	
6. Patient's Name and Address <b>DERVISHIAN, OGANES</b> <b>15044 MAGNOLIA BLVD. #11</b> <b>Sherman Oaks, CA 91403, 818-481-6610</b>					7. Provider's Name, Address, and Telephone Number <b>PROMINENT HOME HEALTH CARE</b> <b>6742 Van Nuys Blvd.</b> <b>Ste. 104</b> <b>VAN NUYS, CA 91405-4611</b> <b>818-666-7154</b> <b>F:818-638-1684</b>				
8. Date of Birth <b>01/11/1936</b>		9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged  <b>Acetaminophen 500 mg 1 tablet by mouth every 6-8 hours as needed for pain</b> <b>Atorvastatin 40 mg 1 tablet by mouth daily</b> <b>Sertraline 25 mg 1 tablet by mouth daily</b> <b>Quetiapine 200 mg 1 tablet by mouth daily</b> <b>Gabapentin 300 mg 1 capsule by mouth every 8 hours as needed for pain</b> <b>Aspirin 81 mg 1 tablet by mouth daily</b> <b>Please See 487</b>					
11. ICD-10-CM <b>G89.4</b>		Principal Diagnosis <b>Chronic pain syndrome</b>		Date <b>09/18/19</b>		E/O			
12. ICD-10-CM		Surgical Procedure		Date					
13. ICD-10-CM <b>M13.0</b> <b>I11.9</b> <b>E11.40</b> <b>G30.1</b> <b>F02.80</b> <b>F32.0</b>		Other Pertinent Diagnoses <b>Polyarthrititis, unspecified</b> <b>Hypertensive heart disease</b> <b>Type 2 diabetes mellitus w/</b> <b>Alzheimer's disease with la</b> <b>Dementia in oth diseases c</b> <b>Major depressive disorder,</b>		Date <b>09/18/19</b> <b>09/18/19</b> <b>09/18/19</b> <b>09/18/19</b> <b>09/18/19</b> <b>09/18/19</b>					
14. DME and Supplies: <b>NON-STERILE GLOVES, ALCOHOL SWABS, INCONTINENCE SUPPLIES, DIABETIC</b>					15. Safety Measures: <b>UNIVERSAL/FALL/BLEEDING PRECAUTIONS, SAFE DISPOSAL SHARPS', DIABETIC</b>				
16. Nutritional Req: <b>NAS, CONTROLLED CARBOHYDRATE, LOW</b>					17. Allergies: <b>None known</b>				
18.A. Functional Limitations					18.B. Activities Permitted				
1 <input type="checkbox"/> Amputation		5 <input type="checkbox"/> Paralysis		9 <input type="checkbox"/> Legally Blind		1 <input type="checkbox"/> Complete Bedrest		6 <input type="checkbox"/> Partial Weight Bearing	
2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence)		6 <input checked="" type="checkbox"/> Endurance		A <input type="checkbox"/> Dyspnea		2 <input type="checkbox"/> Bedrest BRP		7 <input type="checkbox"/> Independent At Home	
3 <input type="checkbox"/> Contracture		7 <input checked="" type="checkbox"/> Ambulation		B <input checked="" type="checkbox"/> Other (Specify)		3 <input checked="" type="checkbox"/> Up As Tolerated		8 <input type="checkbox"/> Crutches	
4 <input checked="" type="checkbox"/> Hearing		8 <input type="checkbox"/> Speech		SOB w mod/exe, poor vision		4 <input type="checkbox"/> Transfer Bed/Chair		9 <input checked="" type="checkbox"/> Cane	
					5 <input checked="" type="checkbox"/> Exercises Prescribed				
19. Mental Status					Assist with ADLs/IADLs				
1 <input checked="" type="checkbox"/> Oriented		3 <input checked="" type="checkbox"/> Forgetful		5 <input type="checkbox"/> Disoriented		7 <input type="checkbox"/> Agitated			
2 <input type="checkbox"/> Comatose		4 <input checked="" type="checkbox"/> Depressed		6 <input type="checkbox"/> Lethargic		8 <input checked="" type="checkbox"/> Other		Anxious/confused at times	
20. Prognosis		1 <input type="checkbox"/> Poor		2 <input type="checkbox"/> Guarded		3 <input checked="" type="checkbox"/> Fair		4 <input type="checkbox"/> Good	
						5 <input type="checkbox"/> Excellent			
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) <b>Admit patient to Prominent Home Health Care, INC for:</b> <b>Skilled Nursing: 2w2, 1w7;</b> <b>REFERRAL PLAN: PHYSICAL THERAPY REFERRAL FOR EVALUATION FURTHER MANAGEMENT AND INTERVENTIONS.</b> <b>Lab work: Per MD order.</b>  <b>SKILLED OBSERVATION &amp; ASSESSMENT ON ALL BODY SYSTEMS WITH EMPHASIS ON:</b> 1) Musculoskeletal status: pain level and control, mobility, weakness and ability to perform ADLs; Chronic pain syndrome; s/s related to Polyarthrititis, such as joint pain, joint swelling, joint stiffness, crepitus. 2) Cardiovascular status: focusing on vital signs and BP trends, breath sounds, dyspnea, and peripheral circulation; s/s related to Hypertension such as high blood pressure, severe headache, nosebleed, dizziness. 3) Endocrine status: blood sugar level, s/s of hypoglycemia/hyperglycemia; s/s related to Diabetes Mellitus such as blurred vision, polyuria, polyphagia, polydipsia; Long term (current) use of oral hypoglycemic drugs. 4) Neurologic/mental status: motor and sensory impairment, psychosocial and coping status; s/s									
22. Goals/Rehabilitation Potential/Discharge Plans Within certification period: 1. Patient has personal goals (controlled VS, improved ADLs, reduce pain) which will be achieved in 3-4 weeks. 2. Patient/PCG will demonstrate compliance with medications.									
23. Nurse's Signature and Date of Verbal SOC Where Applicable: 								25. Date HHA Received Signed POT <b>9/17/2019</b>	
24. Physician's Name and Address <b>FORTALEZA, PAUL PHYSICIAN</b> <b>6350 LAUREL CANYON BLVD. #200</b> <b>North Hollywood, CA 91606, 818-325-2090</b> <b>Fax: (818) 325-2092</b>								26. 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. A face-to-face patient encounter(s) occurred no more than 90 days prior to or within 30 days after the home health start of care, was related to the primary reason the patient requires home health services, and was performed by either the certifying physician, a physician, with privileges, NP in collaboration with certifying physician, PA or certified nurse midwife under the supervision of a certifying physician who cared for the patient in an acute or post-acute facility from which the patient will be directly admitted to home health. <b>The Face-to-Face encounter: 09/17/2019</b>	
27. Attending Physicians Signature and Date Signed (Signature applies to all Pages)								28. 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.	

## ADDENDUM TO:



## PLAN OF TREATMENT



## MEDICAL UPDATE

1. Patient's HI Claim No. 548433916M	2. Start Of Care Date 09/18/2019	3. Certification Period 09/18/2019 - 11/16/2019	4. Medical Record No. 000000066-001	5. Provider No. 553133
6. Patient's Name and Address DERVISHIAN, OGANES 15044 MAGNOLIA BLVD. #11 Sherman Oaks, CA 91403, 818-481-6610		7. Provider's Name, Address, and Telephone Number PROMINENT HOME HEALTH CARE 6742 Van Nuys Blvd. Ste. 104 VAN NUYS, CA 91405-4611 818-666-7154 F: 818-638-1684		

## 10. Medications continued

Hydralazine 25 mg 1 tablet by mouth 3 times daily  
 Losartan 100 mg 1 tablet by mouth daily  
 Carvedilol 12.5 mg 1 tablet by mouth twice daily  
 Memantine 10 mg 1 tablet by mouth twice daily  
 Esomeprazole 40 mg 1 capsule by mouth daily  
 Tolterodine 4 mg 1 capsule by mouth daily  
 Janumet 50/500 mg 1 tablet by mouth twice daily

## 13. Other Pertinent Diagnoses continued

279.84 Long term (current) use of ora 09/18/2019  
 279.82 Long term (current) use of asp 09/18/2019

## 14. DME and Supplies continued

SUPPLIES (GLUCOMETER, SYRINGES, CHEMSTRIPS, LANCETS, SHARPS CONTAINER), BATHBENCH, CANE

## 15. Safety Measures continued

SKIN/FOOT CARE PRECAUTIONS, SAFE USE OF CANE, SAFE USE OF BATHBENCH, CLEAR PATHWAYS, INFECTION CONTROL MEASURES, 911 PROTOCOLS

## 16. Nutrition Req. continued

FAT/CHOLESTEROL DIET

## 21. Orders for Discipline and Treatments continued

related to Alzheimer's disease as memory loss and cognitive decline; s/s related to Dementia such as impaired judgment, incontinence, personality change; s/s related to Depressive Disorder such as irritability, nervousness, withdrawn behavior.

5) GU/GI status: nutrition, hydration, elimination, incontinence.

6) Medication compliance and effectiveness; Long term (current) use of aspirin; s/s related to Aspirin therapy such as unusual pain/swelling/discomfort, unusual bruising, prolonged bleeding from cuts or gums, persistent/frequent nosebleeds, pink/dark urine, coughing up blood, bloody vomit.

7) Safety hazards, fall prevention.

8) Patient/PCG response to teaching.

SN TO PERFORM/TRAIN PCG/PATIENT: VS: Temp/RR/HR/BP/ check every visit. BS (FBS or RBS) check every visit observing infection control measures, safe/proper disposal of sharps/needles. Check location intensity and severity of the pain (scale pain from 0-10), implement pain relief measures and evaluate its effectiveness.

Blood sugar monitoring done by PCG. SN instruct patient/caregiver and validate that PCG competent to monitor blood sugar in aseptic technique and with proper disposal of sharps. However, patient/PCG needs further education regarding DM monitoring/management, and regularly perform diabetic skin/foot exam.

SN TO TEACH PATIENT/PCG ON:

1. Disease process (r/t diagnoses, mentioned on page 1) s/s of exacerbation/potential complications and emergency actions to take.

2. Pain relief measures, including pain medication, relaxation techniques, frequent position changes, good body alignment and correct body mechanics.

3. Safety measures to observe during transfers/ambulation to prevent fall/injury.

4. Energy conservation techniques, activities as tolerated with planned rest periods.

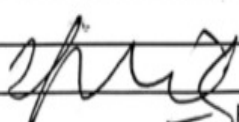
5. Medication regimen, purpose, side effects and compliance to medication regimen.

6. Diet restrictions.

7. Fall precautions.

8. Coping mechanism, universal precautions, 911 protocol and emergency actions to take.

9. DM care including blood sugar monitoring, observing aseptic technique, proper disposal of sharps, and skin and foot care.

9. Signature of Physician	(Signature applies to all Pages)	10. Date
11. Optional Name/Signature of Nurse/Therapist		12. Date 9.17.19
Form CMS 487		Page 2 of 4

Provider



## ADDENDUM TO:



## PLAN OF TREATMENT



## MEDICAL UPDATE

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10. High alert medications, importance of taking as prescribed, side effects.

11. Bleeding precautions, such as unusual pain/swelling/discomfort, unusual bruising, prolonged bleeding from cuts or gums, persistent/frequent nosebleeds, pink/dark urine, coughing up or vomiting blood.

SN TO REPORT TO PMD THE FOLLOWING PARAMETERS: s/s of infection; pain level greater than 6/10 and or not relieved with pain medication, Blood Sugar: FBS less 60 mg/dl or above 300 mg/dl, RBS less 60 mg/dl or above 400 mg/dl, unless specified by attending physician, symptomatic of hypo/hyperglycemia. SBP greater than 160mmHg and less than 90mmHg; DBP greater than 100mmHg & less than 50mmHg with s/sx of Hypertensive crisis; HR: less than 60/min and greater than 100/min. Increasing SOB/dyspnea not relieved with rest, mucus production, fever (T-100.0F), cyanosis, RR: less than 14/min and greater than 24/min. Report to MD regarding any significant change in clinical status, fall/injury incident, ER visit/hospitalization occurrence. Report s/s of bleeding related to Aspirin therapy.

PT: Evaluation and assessment to determine patient's condition and physical therapy needs, provision of therapeutic/strengthening exercises, balance/coordination training, mobility/ROM exercises, gait/transfer training, home safety, PCG education on home exercise program and proper body mechanics; frequency of visits to follow post-evaluation/assessment.

## 22. Goal/Rehabilitation Potential/Discharge Plans continued

3. Within 4-6 weeks patient will show improvement in musculoskeletal status as evidenced by improved pain control, mobility, no joint pain, ability to perform ADL. Patient will verbalize pain controlled at acceptable level of 1-2/10.

4. Within 6-8 weeks patient's cardiovascular condition will stabilize as evidenced by vital signs within normal parameters with BP in the range 90-140 mmHg systole and 60-90 mmHg diastole, clear breath sounds, and no s/s of increased dyspnea.

5. Within 6-8 weeks patient/PCG will demonstrate independence with DM care with patient's BS stabilizing within 70-200mg/dl asymptomatic of hypo/hyperglycemia, will demonstrate compliance to prescribed diet/diabetic regimen, will verbalize/demonstrate knowledge of regularly perform diabetic skin/foot exam.

6. Within 6-8 weeks patient will show improvement of neurological/mental condition, patient/PCG will verbalized reduce s/s of depression, and dementia.

7. Patient will not develop any adverse effects of High risk medications. No falls/injuries/bleeding/ hospitalizations during episode of care.

8. Patient will not have any s/s of bleeding related to Aspirin therapy such as unusual pain/swelling/discomfort, unusual bruising, and prolonged bleeding from cuts or gums, persistent/frequent nosebleeds, pink/dark urine, coughing up or vomiting blood.

9. Patient will achieve PT goals and demonstrate ability to follow home exercise program, improved strength/endurance, ability to perform safe transfer/ambulation (with or without assistive device), improved balance/coordination.

REHABILITATION POTENTIAL: Fair for patient to achieve partial return to a previous higher level of function.

DISCHARGE PLAN: Discharge patient in a safe living environment with PMD follow up appointments and supervision, under family/caregiver for minimal assistance with ADLs/IADLs.

DISCHARGE SUMMARY WILL BE AVAILABLE FOR PRIMARY CARE PHYSICIAN

## 99. Item 99

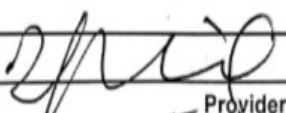
VITAL SIGNS UPON EVALUATION: Blood pressure: 149/92 mmHg. Blood sugar: 190 mg/dL; Temperature: 98.0 F; Radial pulse: 87, Respiration: 18 regular. Height: 66 reported. Weight: 175 lbs.

Confined to home (homebound):

Criteria- One:

1. Because of illness or injury, need the aid of supportive device such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

Criteria- Two:

9. Signature of Physician	(Signature applies to all Pages)	10. Date
11. Optional Name/Signature of Nurse/Therapist		12. Date 9.17.19
Form CMS 487		Page 3 of 4

- Provider

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## PLAN OF TREATMENT



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1. There must exit a normal inability to leave home (pain, unsteadiness on feet, confused).
2. Leaving home must require a considerable and taxing effort.

## RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM:

Reported or observed history of difficulty complying with any medical instructions (medications, diet, exercise, safety measures) in the past 3 months; Currently taking 5 or more medications; Currently reports exhaustion.

## Actions:

- PT/PCG education, medications reconciliation every SN visit.
- Teach actions and side effects of medications, disease process, s/s of exacerbation of chronic illness, assess Pt's ability, knowledge, resources, adhere.

## FULL CODE

DNR PHYSICIAN ORDERS-NONE

Power of Attorney/Advance healthcare directive - NONE

SAFETY CONCERNS/FUNCTIONAL LIMITATIONS: Patient is at risk of fall due to multiple risk factors, including, age, sensory deficit and physical limitation, medications and health condition affecting oxygenation and perfusion. Patient/PCG has insufficient knowledge regarding disease process, medications and safety at home.

## FALL PREVENTION MEASURES ARE INITIATED.

MAHC 10 FALL RISK ASSESSMENT: TOTAL SCORE 8

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM MEDICAL PRACTITIONER (MD, DO, DDM) WHO MAY BE INVOLVED IN THE CARE OF THE PATIENT.

EMERGENCY TRIAGE CODE: MEDIUM

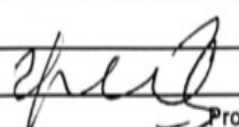
EMERGENCY CONTACT: Garry

RELATIONSHIP: son

Phone: 818 481 6011

SN TO EDUCATE PATIENT/PCG ON FALL PREVENTION STRATEGIES SPECIFIC TO AREAS OF RISK AND TO MONITOR AREAS OF RISK TO REDUCE FALL

POC AND ALL HEALTH CARE INSTRUCTIONS/CONSENTS INTERPRETED FOR PATIENT BY RN

9. Signature of Physician	(Signature applies to all Pages)	10. Date
11. Optional Name/Signature of Nurse/Therapist		12. Date 9/17/19
Form CMS 487		Page 4 of 4