Department of Health and Human Services
Centers for Medicare & Medicaid Services

Certification [ ] Recertification [X]

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
467824140A	5/10/2012	From: 9/7/2012 To: 11/5/2012	393-02	457978

6. Patient's Name and Address
Garcia, Abel G.
4046 Odessa ST
Dallas Texas 75212
Phone: 214 643 3020

7. Provider's Name, Address and Telephone Number
OPTIMUM HOME HEALTH CARE INC
5501 INDEPENDENCE PKWY SUITE 101
PLANO, TX - 75023
Phone: 972 596 6442

8. Date of Birth 12/23/1948

9. Sex [X] M [ ] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
BENAVITE 1 TAB QD PO
TYLENOL 500MG 1 TAB PO Q 4-6HRS PO PRN PAIN
SENSIPAR 30MG 1 TAB QD PO
RENVELA 800MG 2TAB TID PO
GABAPENTIN 300MG 1 TAB Q HS PO
AMLODIPINE 5MG 1 TAB PO QD (N)

11. ICD-9-CM	**Principal Diagnosis**	**Date**
40291	HYPERTEN HEART DIS W CHF	9/4/2012
12. ICD-9-CM	**Surgical Procedure**	**Date**
13. ICD-9-CM	**Other Pertinent Diagnoses**	**Date**
25060	DMII NEURO NT ST UNCNTRL ()	9/4/2012
3572	NEUROPATHY IN DIABETES ()	9/4/2012
42841	AC SYST/DIASTOL HRT FAIL ()	5/10/2012

14. DME and Supplies
GLOVES

15. Safety Measures:
FALLS

16. Nutritional Req. LOW NA

17. Allergies: NKA

18.A. Functional Limitations

1 [ ]	Amputation	5 [ ]	Paralysis	9 [ ]	Legally Blind		
2 [ ]	Bowel/Bladder (Incontinence)	6 [X]	Endurance	A [X]	Dyspnea With Minimal Exertion		
3 [ ]	Contracture	7 [X]	Ambulation	B [X]	Other (Specify)		
4 [X]	Hearing	8 [ ]	Speech				

18.B. Activities Permitted

1 [ ]	Complete Bedrest	6 [ ]	Partial Weight Bearing	A [ ]	Wheelchair
2 [ ]	Bedrest BRP	7 [ ]	Independent At Home	B [ ]	Walker
3 [X]	Up As Tolerated	8 [ ]	Crutches	C [ ]	No Restrictions
4 [ ]	Transfer Bed/Chair	9 [X]	Cane	D [ ]	Other (Specify)
5 [ ]	Exercises Prescribed				

19. Mental Status: 1 [X] Oriented 2 [ ] Comatose 3 [X] Forgetful 4 [ ] Depressed 5 [ ] Disoriented 6 [ ] Lethargic 7 [ ] Agitated 8 [ ] Other

20. Prognosis: 1 [ ] Poor 2 [ ] Guarded 3 [X] Fair 4 [ ] Good 5 [ ] Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

SNV: 1W8 BEGIN WEEK OF 09/09/12
SN TO RECERTIFY PATIENT FOR HOME CARE SERVICES. ASSESS ALL SYSTEMS, vrs Q_VISIT AND NOTIFY MD IF B/P >160/90 <90/40 P>100 <50 R>25 <12 T>101.0 <96 OR RANDOM BS >300 <70, FASTING BS >200 <60 PAIN >5 ON A SCALE OF 0-10, 02 SAT MONITOR WITH S/S OF SOB AND NOTIFY 02 SAT <92%.
SN TO TO OBTAIN WEIGHT AND NOTIFY DR WITH S/S OF CHF SUCH AS BP ELEVATION, EDEMA, ABNORMAL BREATH SOUNDS-RALES,CRACKLES, INCREASING SOB OR ANY ABNORMAL FINDINGS.

SN TO ASSESS/INSTRUCT PT IN ALL ASPECTS OF DISEASE PROCESSESS, S/SX OF EXACERBATIONS, HOME MANAGEMENT OF DISEASE PROCESS(ES) AND WHEN TO NOTIFY NURSE OR PHYSICIAN.

SN TO CHECK BS EACH SNV IF NOT DONE BY PT/CG. SN TO EDUCATE PT/CG ALL ASPECTS OF DIABETIC EDUCATION INCLUDING APPROPRIATE CONTROL MEASURES, ACTIVITY, STRESS, INFECTION, SKIN AND FOOT CARE MEASURES. PT'S DIABETES CONTROLLED WITH DIET.

SN TO INSTRUCT ON DX OF OSTEOARTHROSIS, PAIN MANAGEMENT AND USE OF ROUND THE CLOCK PAIN MEDICATION, DEMONSTRATE PROPER BODY MECHANICS IN AMBULATING AND TRANSFERING,

22. Goals/Rehabilitation Potential/Discharge Plans
PT WILL VERBALIZE KNOWLEDGE OF DISEASE PROCESS S/S OF EXACERBATIONS AND WHEN TO NOTIFY MD BY EOE.

PT WILL HAVE NO FURTHER EXACERBATION OF DISEASE PROCESSES DURING CERT PERIOD.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
9/4/2012

25. Date HHA Received Signed POT
2/21/2013

24. Physician's Name and Address
Dr. Ketha, Sumana
2925 Skyway Cir N
irving TX
75038
Phone:972 675 7313 NPI:1962447805

26. I certify/recertify 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. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed
Sketha M.D
2/21/2013

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** [X] **MEDICAL UPDATE** [ ]

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13b

ICD-9-CM	Other Pertinent Diagnoses	Date
36250	MACULAR DEGENERATION NOS ()	5/10/2012
5856	END STAGE RENAL DISEASE ()	5/10/2012
2900	SENILE DEMENTIA UNCOMP ()	4/23/2012
V4511	RENAL DIALYSIS STATUS ()	4/23/2012
715.16	OSTEOARTHROSIS L/LEG ()	-

14 DME and Supplies
TEMP PROB CAVER
DM SUPPLIES

15 Safety Measures
INFECTION CONTROL/ STANDARD PRECAUTIONS
BLEEDING PREC.
SHARPS PREC.
EMERGENCY PREP 4

16 Nutritional Req.
LOW FAT
NCS
RENAL

21 Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
SAFETY MEASURES TO PREVENT FALL/INJURY.

SN TO INSTRUCT ON MEASURES TO RECOGNIZE CARDIAC DYSFUNCTION AND RELIEVE COMPLICATIONS

SN TO EDUCATE MEASURES TO CONTROL HTN SUCH AS; TAKE MEDS AS PRESCRIBED, AVOID EXCESS STRESS, SAT. FAT, NA, LOSE WEIGHT, EXERCISE REGULARLY.

SN TO ASSESS/INSTRUCT PT MANAGEMENT OF HTN, OSTOEARTHROSIS, MACULR DEGENERATION, NEUROPATHY, DEMENTIA WITHOUT EXACERBATION

SN TO PALPATE PT'S RT ARM DIALYSIS SHUNT FOR BRUIT, AUSCULTATE FOR THRILL Q VISIT, OBSERVE FOR AND REPORT INDICATIONS OF INFECTION: PRESENCE OF ERYTHEMA, LOCAL WARMTH, SWELLING, EXUDATE AND UNUSUAL TENDERNESS AT THE GRAFT SITE.

SN TO ASSESS PATIENT'S RESPONSE TO NEW/CHANGED MEDICATIONS, INSTRUCT PT IN MEDICATION REGIME, INCLUDING SCHEDULE, PURPOSE, AND POSSIBLE SIDE EFFECT OR ADVERSE REACTIONS.

SN TO PREFILL MED BOX Q WEEK AND PRN MED CHANGES

SN TO ASSESS/INSTRUCT PT'S NUTRITION REQUIREMENTS AND HYDRATION STATUS.

SN TO ASSESS/INSTRUCT PT IN HOME SAFETY/FALL PRECAUTIONS AND EMERGENCY PREPAREDNESS.

SN TO ASSESS/INSTRUCT PT ON INTERVENTIONS IN PAIN MANAGEMENT, INCLUDING PHARMACOLOGICAL AND COMFORT MEASURES

MAY HOLD HHC SERVICES IF PT TX TO INPATIENT FACILITY AND WILL RESUME CARE WHEN D/C HOME.

HOME HEALTH MAY RECEIVE ORDERS FROM PT' S OTHER PHYSICIANS.

22 Goals/Rehabilitation Potential/Discharge Plans
PT'S ACCESS IS PATENT AS EVIDENCED BY PRESENCE OF THRILL WITH PALPATION AND BRUIT WITH AUSCULTATION OF FISTULA. PT WILL BE FREE FROM INFECTION AS EVIDENCED BY ABSENCE OF

9. Signature of Physician	10. Date
S. Kothe M.D	2/21/2013
11.Optional Name/Signature of Nurse/Therapist	12. Date
[signature]	9/4/2012

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	ERYHTEMA, LOCAL WARMTH/ SWELLING AT THE ACCESS SITE. PT WILL EXPERIENCE THERAPEUTIC RESPONSE TO MEDICATIONS DURING CERT PERIOD AND COMPLY WITH MED REGIMEN THROUGHOUT CERT PERIOD PT'S BP WILL BE WITHIN DEFINED LIMITS THROUGHOUT EPISODE PT'S BS WILL BE WITHIN DEFINED LIMITS THROUGHOUT EPISODE PT WILL HAVE NO S/SX OF CARDIAC COMPLICATION THROUGHOUT EPISODE PT WILL BE ABLE TO DEMONSTRATE COMPETENCE IN MANAGEMENT OF HTN, OSTOEARTHROSIS, MACULR DEGENERATION, NEUROPATHY, DEMENTIA BY EOE. PTS PAIN WILL BE BETTER CONTROLLED TO A TOLERABE LEVEL BY THE END OF 60 DAY EPISODE AS EVIDENCE BY VERBALIZATION IN HOME SAFETY WILL BE PROMOTED AS EVIDENCE BY NO FALLS OR INJURIES DURING 60 DAY EPISODE. FAIR FOR MEDICAL CONDITION IF COMPLIANT WITH PLAN OF CARE DC PATIENT TO CG UNDER MD F/U WHEN ABOVE GOALS MET AND SKILLED SERVICES NO LONGER NEEDED 99. D/C SUMMARY AVAILABLE UPON REQUEST
18a	Functional Limitations, Others IMPAIRED VISION

9. Signature of Physician	10. Date
S. Kothe M.D	2/21/2013
11.Optional Name/Signature of Nurse/Therapist	**12. Date**
[signature]	9/4/2012