

**INTEGRIS****HOME HEALTH CARE**

Integrity Excellence Commitment

**INTEGRIS HOME HEALTH CARE, LLC**

2735 VILLA CREEK DRIVE • SUITE 142 • DALLAS, TEXAS 75234

PHONE: 972-249-4999 / 817-628-0600 • FAX: 972-468-6991

FROM: Shelly TO: Dr. Ketha

CONTACT NUMBER: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_ ORGANIZATION: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ FAX NUMBER: 916757310

PAGES: \_\_\_\_\_

## NOTES:

485  
New Cert Period 2-2015 - 4-2015

Please sign date & fax back

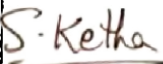
Thank you.

**FAXED**  
3/2/15

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

Form Approved OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE				
1. Patient's HI Claim No. 448607490C2		2. Start Of Care Date 10/23/2014		3. Certification Period From: 02/20/2015 To: 04/20/2015
		4. Medical Record No. IHHC-127		5. Provider No. 747682
6. Patient's Name and Address Alsip, Jeromy 3831 MEHALIA DR. Dallas, TX 75241 (469) 233-1544			7. Provider's Name, Address and Telephone Number Integris Home Health Care, LLC 2735 VILLA CREEK PARKWAY, STE 142, Dallas, TX 75234 Phone: (972) 249-4999   Fax: (972) 468-6991 Email: sraju@integrisihc.com	
8. Date of Birth 10/19/1983		9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged INVEGA SUSTENNA 234 MG/1.5 ML INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE prn Intramuscular (IM) U DEPAKOTE DR 500 MG 500 MG TWICE DAILY By mouth (PO) C LORAZEPAM 2 MG ORAL TABLET 1 tab QID By mouth (PO) U THORAZINE 100 MG ORAL TABLET ONE TAB THREE TIMES DAILY By mouth (PO) U AMLODIPINE 10 MG ORAL TABLET daily By mouth (PO) U TRAZODONE 100 MG ORAL TABLET 1 tab at bedtime prn By mouth (PO) U
11. ICD-9-CM 401.1	Principal Diagnosis Benign hypertension	Date 02/18/2015		
12. ICD-9-CM	Surgical Procedure	Date		
13. ICD-9-CM 715.09 728.87 427.9 413.1	Other Pertinent Diagnoses General osteoarthritis Muscle weakness-general Cardiac dysrhythmia NOS Prinzmetal angina	Date 12/18/2014 01/26/2015 01/26/2015 10/23/2014		
14. DME and Supplies DME NOT PRESCRIBED, Exam Gloves, Probe Covers, DIGITAL			15. Safety Measures: Fall Precautions, Keep Pathway Clear, Safety in ADLs, Slow Position	
16. Nutritional Req. Heart Healthy.			17. Allergies: NKA (Food/Drugs/Latex/Environment)	
18.A. Functional Limitations			18.B. Activities Permitted	
1 <input type="checkbox"/> Amputation      5 <input type="checkbox"/> Paralysis      9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence)      6 <input type="checkbox"/> Endurance      A <input type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture      7 <input checked="" type="checkbox"/> Ambulation      B <input checked="" type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing      8 <input type="checkbox"/> Speech <b>POOR SAFETY AWARENESS</b>			1 <input type="checkbox"/> Complete Bedrest      6 <input type="checkbox"/> Partial Weight Bearing      A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP      7 <input type="checkbox"/> Independent At Home      B <input type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated      8 <input type="checkbox"/> Crutches      C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair      9 <input type="checkbox"/> Cane      D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed	
19. Mental Status:			19. Mental Status:	
1 <input checked="" type="checkbox"/> Oriented      3 <input type="checkbox"/> Forgetful      5 <input type="checkbox"/> Disoriented      7 <input type="checkbox"/> Agitated 2 <input type="checkbox"/> Comatose      4 <input type="checkbox"/> Depressed      6 <input type="checkbox"/> Lethargic      8 <input type="checkbox"/> Other				
20. Prognosis:			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) SN Frequency: 1W9. PT Frequency: Eval and treat. MSW Frequency: 1-2 VISTS PRN PER CERTIFICATION PERIOD. SN PRN 1-2 VISIT (S) FOR TACHYCARDIA, PAIN, HYPERTENSION. SN TO RESUME CARE IF PATIENT ADMITTED AND DISCHARGE FROM THE HOSPITAL DURING THE CERTIFICATION PERIOD. SN to notify MD of: Temperature greater than (>) 100.0 or less than (<) 96.0. Pulse greater than (>) 100 or less than (<) 60. Respirations greater than (>) 24 or less than (<) 12. Systolic BP greater than (>) 160 or less than (<) 90. Diastolic BP greater than (>) 90 or less than (<) 60. O2 Sat (percent) less than (<) 90. Weight Gain/Loss (lbs/7 days) Greater than 5. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unsafe to leave home due to cognitive or psychiatric impairments; MSW to assess psychosocial needs, environment and assist with community referrals and resources.				
22. Goals/Rehabilitation Potential/Discharge Plans Patient will have absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs by the end of the episode. SKIN WILL REMAIN INTACT. Respiratory status will improve with reduced shortness of breath and improved lung sounds by the end of the				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Monica Todd RN 02/18/2015			25. Date HHA Received Signed POT	
24. Physician's Name and Address Ketha, Sumana MD NPI: 1962447805. 2925 Skyway Cir N Irving TX 75038 Phone: (972) 675-7317   Fax: (972) 875-7310			26. I certify/reconfirm 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  Electronically signed by Ketha, Sumana M.D. on 03/03/2015			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.	


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## ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 448607490C2	2. Start Of Care Date 10/23/2014	3. Certification Period From: 02/20/2015 To: 04/20/2015	4. Medical Record No. IHHC-127	5. Provider No. 747682
6. Patient's Name: Alsip, Jeromy		7. Providers Name Integris Home Health Care, LLC		
10. Medications HALOPERIDOL 10 MG ORAL TABLET 10 mg once at night By mouth (PO) U DIPHENHYDRAMINE 50 MG ORAL CAPSULE 50 mg tablet every six hours By mouth (PO) U HALDOL 5 MG ORAL TABLET one tab every morning By mouth (PO) C BENZTROPINE 1 MG ORAL TABLET one tablet in the morning and one tab at night. By mouth (PO) N propanolol 10 mg once daily By mouth (PO) N				
13. Diagnoses 724.3 / Sciatica / 10/23/2014 333.99 / Extrapyrimalal dis NEC / 10/23/2014 296.90 / Episodic mood disord NOS / 10/23/2014 V58.69 / Long-term use meds NEC / 10/23/2014				
14. DME and Supplies SCALE FOR WEIGHT MONITORING. BLOOD PRESSURE MONITOR THERMOMETER PULSE OXIMETER				
15. Safety Measures Change, Standard Precautions/Infection Control, Instructed on mobility safety, Instructed on safety measures				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)  SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5/10, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN TO ASSESS AND INSTRUCT PATIENT/GROUP HOME MANAGER/ASSISTANT TO EXAMINE BILATERAL LOWER EXTREMITIES. SN to assess O2 saturation on room air (freq) Q SN VISIT. SN to instruct the Patient/Caregiver to avoid smoking or allowing people to smoke in patient's home. Instruct patient to avoid irritants/allergens known to increase SOB. SN to instruct patient on energy conserving measures including frequent rest periods, small frequent meals, avoiding large meals/overeating, controlling stress. Report to physician O2 saturation less than 90%. SN to perform weekly weights. SN to instruct patient on daily weight self-monitoring program, and to report weight gain of lbs/day, 5lbs/week. SN to assess patient's weight log every visit. SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911. SN to teach on daily BP/HR checks and logging. SN to instruct on establishing bladder regimen. SN to instruct Patient/Caregiver on HEART HEALTHY diet. SN to assess patient for diet compliance. SN to perform a neurological assessment each visit. Physical therapy to evaluate. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to change positions slowly. SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause patient to trip. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility.				
9. Signature of Physician:  Electronically signed by Ketha, Sumana M.D on			10. Date: 03/03/2015	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN			12. Date 2/18/2015	

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21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN to determine if the Patient/Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient/Caregiver can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment.				
22. Goals/Rehabilitation Potential/Discharge Plans episode. Patient will verbalize an understanding of energy conserving measures by: EOE. The Patient/Caregiver will verbalize understanding of symptoms of cardiac complications and when to call 911 by 04/20/2015. The patient/caregiver will verbalize and demonstrate BP/HR checks and logging. Patient will be without signs/symptoms of UTI (pain, foul odor, cloudy or blood-tinged urine and fever) during this episode. Patient will maintain HEART HEALTHY diet compliance during the episode. Neuro status will be within normal limits and free of S&S of complications or further deterioration. PHYSICAL THERAPY GOALS PER PHYSICAL THERAPIST. The patient will be free from falls during the episode. The patient will be free from injury during the episode. Patient will remain free of adverse medication reactions during the episode. Rehab Potential: Fair for stated goals. Discharge when goals met.				
9. Signature of Physician:  Electronically signed by Ketha, Sumana M.D.			10. Date: 03/03/2015	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN			12. Date 2/18/2015	