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: 9675310

PAGES:

NOTES:
485
New Cert Period 2-2015 – 4-2015

Please sign date & fax back

Thank you.

FAXED 3/2/15

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

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.
448607490C2	10/23/2014	From: 02/20/2015 To: 04/20/2015	IHHC-127	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@integrishhc.com

8. Date of Birth 10/19/1983 **9. Sex** [X] M [ ] F

11. ICD-9-CM	Principal Diagnosis	Date
401.1	Benign hypertension	02/18/2015

12. ICD-9-CM	Surgical Procedure	Date

13. ICD-9-CM	Other Pertinent Diagnoses	Date
715.09	General osteoarthrosis	12/18/2014
728.87	Muscle weakness-general	01/26/2015
427.9	Cardiac dysrhythmia NOS	01/26/2015
413.1	Prinzmetal angina	10/23/2014

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

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

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

19. Mental Status: 1 [X] Oriented 2 [ ] Comatose 3 [ ] 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)
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) 675-7310

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

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.

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

Form Approved
OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
448607490C2	10/23/2014	From: 02/20/2015 To: 04/20/2015	IHHC-127	747682

6. Patient's Name:	7. Providers Name
Alsip, Jeromy	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 / Extrapyramidal 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:	10. Date:
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN	12. Date 2/18/2015

Form CMS-487 (U4)(4-87)

Department of Health and Human Services
Centers for Medicare Medicaid Services

Form Approved
OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period.	4. Medical Record No.	5. Provider No.
448607490C2	10/23/2014	From: 02/20/2015 To: 04/20/2015	IHHC-127	747682

6. Patient's Name:	7. Providers Name
Alsip, Jeromy	Integris Home Health Care, LLC

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 THREAPIST.
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:	10. Date:

11. Optional Name / Signature of Nurse / Therapist	12. Date
Electronically Signed by: Monica Todd RN	2/18/2015

Form CMS-487 (U4)(4-87)