

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 467824140A		2. Start Of Care Date 5/10/2012		3. Certification Period From: 11/6/2012 To: 1/4/2013		4. Medical Record No. 393-02		5. Provider No. 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> 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							
11. ICD-9-CM 25060		Principal Diagnosis DMII NEURO NT ST UNCNTRL								Date 11/2/2012	
12. ICD-9-CM		Surgical Procedure								Date	
13. ICD-9-CM 3572 40291 42841		Other Pertinent Diagnoses NEUROPATHY IN DIABETES () HYPERTEN HEART DIS W CHF () AC SYST/DIASTOL HRT FAIL ()								Date 11/2/2012 11/2/2012 5/10/2012	
14. DME and Supplies GLOVES					15. Safety Measures: FALLS						
16. Nutritional Req. LOW NA					17. Allergies: NKA						
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 A <input type="checkbox"/> Wheelchair						
2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input checked="" type="checkbox"/> Dyspnea With Minimal Exertion					2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker						
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 C <input type="checkbox"/> No Restrictions						
4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech					4 <input type="checkbox"/> Transfer Bed/Chair 9 <input checked="" 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 checked="" type="checkbox"/> Forgetful 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated					1 <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					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					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)											

SNV: 1W9

SN TO RECERTIFY PATIENT FOR HOMECARE SERVICES. ASSESS ALL SYSTEMS, viS 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, INCR~SING SOB OR ANY ABNORMAL FINDINGS.

SN TO ASSESS/INSTRUCT PT IN ALL ASPECTS OF DISEASE PROCESSES, 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 OSTEOARTHRITIS, PAIN MANAGEMENT AND USE OF ROUND THE CLOCK

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: 11/1/2012		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  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



MEDICAL UPDATE



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14 DME and Supplies TEMP PROBE COVER DM SUPPLIES																																	
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16 Nutritional Req. LOW FAT NCS RENAL																																	
21 Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PAIN MEDICATION, DEMONSTRATE PROPER BODY MECHANICS IN AMBULATING AND TRANSFERING, SAFETY MEASURES TO PREVENT FALL/INJURY. SN TO EDUCATE MEASURES TO CONTROL HTN SUCH AS MONITOR BP AT HOME, TAKE MEDS AS PRESCRIBED, AVOID EXCESS STRESS, SAT. FAT, NA, STOP SMOKING, LOSE WEIGHT, EXERCISE REGULARLY. 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, OSTEOARTHRITIS, MACULAR 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																																	
9. Signature of Physician 								10. Date 2/21/2013																									
11. Optional Name/Signature of Nurse/Therapist 								12. Date 11/1/2012																									



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