Department of Home 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. |
|---|---|---|---|---|
| 12233319 | 09/06/2012 | From: 09/06/2012 To: 11/04/2012 | ADB3319 | 677805 |

6. Patient's Name and Address:
ADAMS, BETTY
272 W. LAWSON RD. LOT #28
DALLAS, TX 75253 - (214) 772 6005

7. Provider's Name, Address, Telephone Number and Fax Number:
Prolink Home Health Corporation
8500 N. Stemmons Frwy. Suite 3000
DALLAS TX 75247
Tel: (214) 267 1985 Fax: (214) 267 1983

8. Date Of Birth: 10/30/1939 9. Sex ☐ M ☒ F

| 11.ICD-9-CM | Principle Diagnosis | Date |
|---|---|---|
| 493.20 | CHRONIC OBSTRUCTIVE ASTHMA NO STATUS ASTHMATICUS | |

| 12.ICD-9-CM | Surgical Procedure |
|---|---|
| | |

| 13.ICD-9-CM | Other Pertinent Diagnosis | Date |
|---|---|---|
| 278.00 | OBESITY, UNSPEC | |
| 402.10 | BENIGN HYPERTENSIVE HEART DISEASE WITHOUT CONGESTIVE HEART FAILURE | |

10. Medications:

| | Dose / | Frequency / | Route / | (N)ew (C)hanged |
|---|---|---|---|---|
| LEVOTHYROXINE SODIUM TABLET 0.05MG | 1 TAB | QD | PO | E |
| CITALOPRAM 40MG | 1 TAB | QD | PO | E |
| MECLIZINE HCL TABLET 25MG | 1 TAB | BID PRN | PO | E |
| OMEPRAZOLE DELA YED-RELEASE CAPSULE 20MG | 1 TAB | QD | PO | N |
| CALCIFEROL TAB 50,000IU | 1 TAB | Q MONTH | PO | E |
| HYDROXYZINE HCL TAB 25MG | 1 TAB | Q 8HR PRN | PO | E |

14. DME and Supplies:
GLOVES

15. Safety Measure:
INFECTION CONTROL, HOME SAFETY, SECURE FOOTWEAR,

16. Nutritional Req.: 2 GM NA

17. Allergies: NAPROXEN, ALPHAGEN, EGG, PILOCARPIN, CELEBREX,

18.A Functional Limitations
1 ☐ Amputation
2 ☒ Bladder Incontinence
3 ☒ Bowel Incontinence
4 ☐ Contracture
5 ☐ Hearing
6 ☐ Paralysis
7 ☒ Endurance
8 ☒ Ambulation
9 ☐ Speech
10 ☒ Legally Blind
11 ☒ Dyspnea with Exertion
12 ☐ Other(Specify)
13 ☒ Visual Impairment
14 ☒ Requires max. assistance/taxing effort to leave home
15 ☐ Nonambulatory
16 ☐ Tremors

18.B Activities Permitted
1 ☐ Complete Bed rest
2 ☐ Bedrest BRP
3 ☒ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☒ Exercise Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independant at Home
8 ☐ Crutches
9 ☐ Cane
☐ Confusion unsafe to leave home
☒ Unable to leave home unassisted
A ☐ Wheel Chair
B ☒ Walker
C ☒ R/A c Ambulatio
D ☒ Other(Specify) HOSPITAL BED

19. Mental Status: 1 ☒ Oriented 2 ☐ Comatose 3 ☒ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 9 ☐ Anxious 10 ☒ Confusion 8 ☐ Other:

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☒ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline & Treatments(Specify Amount/Frequency/Duration:If no Frequency & Duration Listed, that Specific Displine has not been ordered)
SN: 1W1, 2W2,1W6

SN TO ASSESS KNOWLEDGE DEFICITS AND INSTRUCT ACCORDINGLY: SN TO ASSESS AND EVALUATE: VITAL SIGNS, MUSCULOSKELETAL STATUS, MEDICATIONS DE/SE, S/S OF COMPLICATIONS, DISEASE PROCESSES, RESPONSE TO MEDS, FUNCTIONAL MOBILITY, RESP.STATUS, NEURO STATUS, EDEMA, CARDIAC STATUS, LEVEL OF PAIN, URINARY STATUS. SN TO INSTRUCT CLIENT: CARE GIVER, FOR NOTED DEFICITS IN: DISEASE PROCESSES, EMERGENCY PROCEDURES, MEDS DE/ SE/ SCHEDULE, MANAGEMENT OF EDEMA, COMFORT/ SAFETY MEASURES, SKIN CARE, THERAPEUTIC

22. Goals/Rehabilitation Potential /Discharge Plans
1. PT/CG WILL REPORT S/S OF PROBLEMS AFTER SN INSTRUCTIONS WITHIN 60 DAYS.
2. PT/CG WILL HAVE KNOWLEDGE RE: MEDICATION REGIMEN WITH COMPLIANCE NOTED BY PROPER ADMINISTRATION WITHIN 30 DAYS.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Digitally Signed By JOSEPHINE CHIDI, RN. 09/06/2012

25. Date HCA Recieved Signed POT

24. Physician's Name and Address:
SUMANA KETHA 1356565865
2925 SKYWAY CIRCLE NORTH
IRVING TX - 75039- - (972) 675 7313
Fax: (972) 675 7310

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. 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
E-Signed By: Dr. Ketha 10/2/2012

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.

Form CMS-485 (C4) (4-85) (Formerly HCFA-485)
790-0067

**Physician Signature applies to all 3 Pages of this Episodes 485,486 &487

**ADDENDUM TO:** ☒ PLAN OF TREATMENT ☐ MEDICAL UPDATE

| 1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 12233319 | 09/06/2012 | From: 09/06/2012 To: 11/04/2012 | ADB3319 | 677805 |

6. Patient's Name: ADAMS, BETTY

7. Provider Name: Prolink Home Health Corporation

8. Item No.

10

| | | | | |
|---|---|---|---|---|
| HYDROCODONE 5/325MG | 1 TAB | Q 4HR PRN | PO | E |
| SINGULAIR TABLET 10MG | 1 TAB | QD | PO | E |
| CALTRATE 600 TABLET 600MG | 1 TAB | QHS | PO | E |
| ASPIRIN EXTRA STRENGTH TABLET 500MG | 1 TAB | QD | PO | E |
| NYSTATIN CREAM 100,000U/GM | APPLY TO AFFECTED AREA | BID | TOPICALLY | N |
| EYE LUBRICANT OPTH OIN | BOTH EYES | QD | TOPICALLY | E |
| GAS X 125MG | 1 TAB | QD | PO | E |
| LOPERAMIDE HCL TAB 2MG | 1 TAB DIARRHEA | PRN | PO | E |
| IPRATROPIUM BROMIDE SOLUTION 0.02% | 1 TREATMENT | QID | PO | N |
| PROAIR HFA ALBUTEROL SULFATE INHALATION AEROSOL | 2 PUFFS | TID | PO | E |
| ALBUTEROL SULFATE 1.25MG/3ML | 1 NEBULIZER TREATMENT | QID PRN | PO | E |
| ADVAIR DISKUS 250/50 DISK | 1 PUFF | BID | PO | E |
| ARTIFICIAL TEARS OPHTH SOLUTION | 2 DROP TO BOTH EYES | BID | DROPS | E |
| COSOPT OCUMETER OPHTH SOLUTION | 1 DROP TO BOTH EYES | BID | DROPS | E |
| ZOCOR TABLET 20MG | 1 TAB | QHS | PO | E |
| NORVASC TABLET 5MG | 1 TAB | QD | PO | C |
| FLONASE 250/50MCG | 1 PUFF EACH NOSTRIL | Q 12HRS | INHALANT | N |
| POTASSIUM CITRATE 10MEQ | 1 TAB | QD | PO | E |
| XALATAN OPHTH SOLUTION 0.005% | 1 DROP BOTH EYES | BID | DROPS | E |
| LACTOSE ENZYME | 1 TAB | QD | PO | E |
| COLON HEALTH PROBIOTIC | 1 TAB | QD | PO | E |
| OXYGEN | 3L | QHS | PO | E |

13

530.81 ESOPHAGEAL REFLUX

296.20 MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPEC DEGREE

369.20 LOW VISION, BOTH EYES, NOT OTHWISE SPEC

15 ASSIST WITH ALL ACTIVITIES, CLEAR PATHWAYS/NIGHT LIGHTS, SLOW POSITIONING CHANGES, USE OF ASSISTIVE DEVICES, FALL PRECAUTIONS, SAFE O2 USE/NO SMOKING,

17 PCN, CODEIN

21 DIET, S/S COMPLICATION/EXACERBATION, INFECTION CONTROL, PAIN CONTROL, MEASURES TO INITIATE TO PREVENT EXACERBATIONS/COMPLICATIONS OF: ASTHMATIC BRONCHITIS
ASSESS/SUPERVISE/INSTRUCT ON MEDICATION REGIMEN,
SUPERVISE AND INSTRUCT ON INTERVENTIONS TO MONITOR AND MITIGATE PAIN, OTHERS: NOTIFY MD OF PAIN >7/10, ASSESS CARDIOVASCULAR STATUS AND COMPLICATIONS, ASSESS RESPIRATORY STATUS,
ASSESS/SUPERVISE/INSTRUCT IN: O2 ADMINISTRATION @ 3 L/MIN: VIA NC CARE OF O2 EQUIPMENT; SAFETY PRECAUTIONS, ASSESS/SUPERVISE/ INSTRUCT NEBULIZER INHALATION TREATMENT WITH ALBUTEROL AND IPRATOPIUM, SUPERVISE/INSTRUCT ON FALL PREVENTION, CONTACT MD FOR CHANGES IN PATIENT SPECIFIC PARAMETERS FOR CHANGES IN VITAL SIGNS OR OTHER CLINICAL FINDINGS. T >101 < 96, P> 120 < 60, R> 28 < 16, BPS > 180 < 90, BPD > 95 < 50
PAIN INTERVENTION: ON HYDROCODONE5/325MG 1 PO Q 4HRS PRN PAIN

22
3. BP WILL ROUTINELY BE WITHIN PARAMETERS WITHIN 60 DAYS WITH MED REGIMEN.
4. PAIN WILL BE CONTROLLED WITH MEDICATION AND TREATMENT IN 60DAYS
5. BRONCHITIS WILL BE CONTROLLED WITH TREATMENT IN 60DAYS
6. HOSPITALIZATION WILL BE PREVENTED THIS EPISODE.
7. NO SKIN BREAKDOWN IN 60 DAYS.
8. D/C TO FAMILY UNDER MD SUPERVISION WHEN GOALS MET

REHAB POTENTIAL:GOOD.

SN: 1W1, 2W2, 1W6

9. Signature Of Physician E-Signed By: Dr. Ketha

10. Date: 10/2/2012

11. Optional Name/Signature of Nurse/Therapist Digitally Signed By JOSEPHINE CHIDI, RN.

12. Date: 09/06/2012

# Home Health Face-To-Face Encounter Form
## ADDENDUM TO PLAN OF TREATMENT

| 1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period: | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 12233319 | 9/6/2012 | From: 9/6/2012 To: 11/4/2012 | ADB3319 | 677805 |
| 6. Patient's Name: ADAMS, BETTY | | 7. Provider Name: Prolink Home Health Corporation | | |

I Certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: _____

The encounter with the patient was in whole, or part, for the following medical condition, which is the primary reason for home health care (list medical condition):

I certify that, based on my findings, the following services are medically necessary home health services (check all that apply):

☐ Nursing ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Language Pathology ☐ HCA

My clinical findings support the need for the above services because:

WE DO OUR OWN FACE TO FACES. i WILL HAVE ONE SENT OVER. THANKS

Further, I certify that my clinical findings support that this patient is homebound (ie, absences from home require considerable and taxing effort and are for medical reasons or religious sevices or infrequently or of short duration for other reasons) because:

Physician Signature: _____ Date: _____

Physician Name Printed: SUMANA KETHA

**PLEASE FAX THIS FORM TO OUR INTAKE DEPARTMENT**

Prolink Home Health Corporation
8500 N. Stemmons Frwy. Suite 3000
DALLAS, TX 75247-
PHONE NUMBER: (214) 267 1985
FAX NUMBER: (214) 267 1983
prolinkhhc@tx.rr.com

V 1.1

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

Form Approved
OMB No. 0938-0357

# MEDICAL UPDATE AND PATIENT INFORMATION

| 1.Patient's HI Claim No. | 2.SOC Date | 3.Certification Period | 4.Medical Record No. | 5.Provider No. |
|---|---|---|---|---|
| 12233319 | 9/6/2012 | From: 9/6/2012 To: 11/4/2012 | ADB3319 | 677805 |

6.Patient's Name and Address:
ADAMS, BETTY
272 W. LAWSON RD. LOT #28, DALLAS, TX- 75253 - (214) 772 6005

7.Provider's Name
Prolink Home Health Corporation

8. Medicare Covered: ☒ Y ☐ N

9. Date Physician Last Saw Patient: 8/24/2012

10. Date Last Contacted Physician: 9/6/2012

11. Is the Patient Receiving Care in an 1861 (j)(1) Skilled Nursing Facility or Equivalent ? ☐ Y ☒ N ☐ Do not Know

12. ☒ Certification ☐ ReCertification ☐ Modified

13. Dates of Last Inpatient Stay: Admission Discharge

14. Type of Facility:

15. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

CLIENT IS A 73 YEAR OLD FEMALE, WHO WAS REFERRED TO HOME HEALTH SERVICES FOR PROBLEMS RELATED TO CHRONIC OBSTRUCTIVE ASTHMA NO STATUS ASTHMATICUS, ASSESSMENT ON 9/6/2012, BP: 138/86, PULSE 77.00, RESPIRATION 16.00, TEMPERATURE 98.00, WEIGHT: 220.00, SKIN DESCRIPTION: BILATERAL GRION AND PERINEAL AREA REDNESS AND ITCHING.. SN IS REQUIRED TO PERFORM TEACHING.
CLIENT,CG LACKS KNOWLEDGE IN THE FOLLOWING AREAS, DISEASE PROCESS, MEDICATION AND PAIN MANAGEMENT
CLIENT,CG MAY REQUIRE SLOW TEACHING BECAUSE OF , LIMITED EDUCATIONAL BACKGROUND, FORGETFULNESS, IMPAIRED VISION, TEACHING HAS BEEN INITIATED ON PAIN MANAGEMENT, EMERGENCY PREPAREDNESS PROCEDURE AND ADVANCE DIRECTIVE,.
NARRATIVE – PATIENT WITH MULTIPLE MEDICAL PROBLEMS. REFERRED TO HOMECARE TO ASSIST PT/CG MANAGE DISEASE. SN TO ASSESS AND INSTRUCT ON DISEASE PROCESS, MEDICATIONS AND ALL ASPECTS OF CARE. COMPREHENSIVE ASSESSMENT COMPLETED. PATIENT VERBALIZED PAIN LEVEL OF 10/10. PATIENT VERBALIZED PAIN MEDS NOT TAKEN YET. SN INSTRUCTS PT TO DO SO NOW. SN CALLED DR KETHA TO NOTIFY, AWAITING RESPONSE. SN INSTRUCT PT ON OTHER PAIN RELIEF MEASURES, LIKE RELAXATION, SUPPORT PAINFUL AREAS WITH PILLOWS AND TAKE PAIN MEDS BEFORE THE ONSET OF PAIN TO DECREASE THE INTENSITY OF PAIN. INSTRUCT PATIENT TO NOTIFY SN/ MD IF PAIN NOT RELIEVED WITH TREATMENT IN 12HRS. SN REVIEWED WITH PT/CG ADVANCE DIRECTIVE, EMERGENCY PREPAREDNESS PROCEDURE AND EVACUATION PLAN. IN CASE OF AN EMERGENCY, GATHER ALL MEDICATIONS AND PERSONAL INFORMATION/IDENTIFICATION IN A WATER PROOF BAG AND TAKE WITH YOU. VERBALIZED UNDERSTANDING. MD RETURNED CALL WITH NO NEW ORDERS RECEIVED.
CARE PLAN REVIEWED WITH PT/FAMILY INVOLVEMENT. MEDICATION REGIMEN REVIEWED FOR POTENTIAL ADVERSE EFFECTS/DRUG INTERACTIONS, DUPLICATE DRUG THERAPY. VERBAL ORDER OBTAINED AND POC ESTABLISHED WITH PATIENT AND PHYSICIAN INVOLVEMENT. GOALS, REHAB POTENTIAL AND DISCHARGE PLANNING DISCUSSED WITH PT/FAMILY. CARE COORDINATION WITH PT/FAMILY, PHYSICIAN AND LVN..

16. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

FUNCTIONAL LIMITATIONS A PROBLEM DUE TO : SOB WITH MINIMAL EXERTION, LOWER EXTREMITY WEAKNESS, FREQUENT DYSPNEA, POOR VISUAL ACUITY, POOR BALANCE, LIMITED AMBULATION, TRANSFER ASSISTANCE, POOR PERIPHERAL CIRCULATION, DEPRESSION, PAIN, MORBID OBESITY, POOR ENDURANCE, O2 DEPENDENCE.REASON HOMEBOUND SOB, PAIN, UNSTEADY GAIT, REQUIRES ASSISTANCE OF 1-2 PERSONS TO LEAVE HOME.

17. Supplementary Plan of Care of File from Physician Other than Referring Physician:
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan) ☐ Y ☒ N

18. Unusual Home/Social Environment:

OTHER GRANDAUTHER ASSISTS PT WITH ADLS.

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

NONE

20. Specify Any Known Medical and / or Non-Medical Reasons the Patient

None.

21. Signature of Physician** E-Signed By: Dr. Ketha — Date (Mo.,Day, Yr.)

22. Nurse Completing or Reviewing Form

Digitally Signed By JOSEPHINE CHIDI, RN. — Date (Mo.,Day, Yr.) 09/06/2012



**Physician's Signature Applies to all pages of this episode 485. 486 and 487.

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

Form Approved
OMB No. 0938-0357

**ADDENDUM TO:** ☐ **PLAN OF TREATMENT TF** ☒ **MEDICAL UPDATE**

| 1.Patient's HI Claim No. | 2.SOC Date | 3.Certification Period | 4.Medical Record No. | 5.Provider No. |
|---|---|---|---|---|
| 12233319 | 9/6/2012 | From: 9/6/2012 To: 11/4/2012 | ADB3319 | 677805 |

| 6.Patient's Name | 7.Provider's Name |
|---|---|
| ADAMS, BETTY | Prolink Home Health Corporation |

| 8. Item No. | |
|---|---|
| 16. | PRIOR FUNCTIONAL STATUS INCREASED DEPENDENCE WITH ADL'S, HAD PROGRESSIVE DEBILITATION. |

9. Signature of Physician** E-Signed By: Dr. Ketha — 10. Date 10/2/2012

11. Optional Signature of Nurse — Digitally Signed By JOSEPHINE CHIDI, RN. — 12. Date 09/06/2012

Form CMS-486 (C4)(4-86)(Formerly HCFA-486)
790-0067

**Physician's Signature Applies to all pages of this episode 485, 486 and 487.