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FAX

Facsimile Transmitted

To: Dr. SUMANA KETHA

From: MARIELA/PCC

Fax: 972-675-7310

Page:

Phone: (972) 247-3060

Date: 6/24/2016

Re: GARZA VIRGILIO

CC:

☒ **Urgent**

☐ **For Review**

☐ **Please Comment**

☐ **Please Reply**

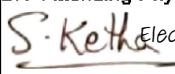
Pls sign and fax back

Thank You


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HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 644015347M	2. Start Of Care Date 04/05/2016	3. Certification Period From: 06/04/2016 To: 08/02/2016	4. Medical Record No. GAV347M	5. Provider No. 679445
6. Patient's Name and Address GARZA, VIRGILIO 2023 CANADA DR Dallas, TX 75212 (214) 664-1837		7. Provider's Name, Address and Telephone Number Family Connections Home Health Care 2321 SOUTH BELTLINE RD. STE 101 BOX 22 Grand Prairie, TX 75051 Phone: (214) 941-9522 Fax: (469) 733-1877 Email: vaishali@fchomehealth.com		
8. Date of Birth 05/13/1943		9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		
10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged DOXAZOSIN 4 MG ORAL TABLET 1 TAB AT BEDTIME By mouth (PO) N SIMVASTATIN 40 MG ORAL TABLET 1TAB AT BEDTIME PO N				
11. ICD- 10-CM I10	Principal Diagnosis Essential (primary) hypertension			Date
12. ICD- 10-CM	Surgical Procedure			Date
13. ICD- 10-CM E78.5	Other Pertinent Diagnoses Hyperlipidemia, unspecified			Date
14. DME and Supplies Cane, Elevated Toilet Seat, Tub/Shower Bench, Exam Gloves, Probe		15. Safety Measures: Anticoagulant Precautions, Emergency Plan Developed, Fall		
16. Nutritional Req. Heart Healthy. Coumadin Diet.		17. Allergies: NIACIN		
18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" 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 CHRONIC PAIN		18.B. Activities Permitted 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 checked="" type="checkbox"/> Independent At Home B <input checked="" 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 checked="" type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed		
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 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed 6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other				
20. Prognosis: 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input checked="" type="checkbox"/> Good 5 <input type="checkbox"/> Excellent				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN Frequency: 1W9,EFFECTIVE,WEEK,OF,06/05/16. SN PRNS FOR FALL/ INFECTION/ MEDICATION CHANGE/ CHANGE IN VITALS. HOLD HOME HEALTH SERVICES UPON ADMISSION TO AN INPATIENT FACILITY, RESUME HOME HEALTH SERVICES WHEN DISCHARGED FROM INPATIENT FACILITY. MAY RECERTIFY PATIENT TO HOME HEALTH CARE SERVICES IF GOALS ARE NOT MET AND CONTINUED SKILLED NEED TO AID IN CONTINUITY OF CARE FOR THE NEXT 60 DAYS. DISCHARGE SUMMARIES WILL ARE SUBMITTED VIA PHYSICIAN REQUEST. SN MAY OBTAIN URINALYSIS AND URINE CULTURE AND SENSITIVITY (C&S) TEST AS NEEDED FOR SIGNS / SYMPTOMS OF UTI, TO INCLUDE PAIN, FOUL ODOR, CLOUDY OR BLOOD-TINGED URINE AND FEVER. SN to notify MD of: Temperature greater than (>) 100.5 or less than (<) 98. Pulse greater than (>) 100 or less than (<) 60. Respirations greater than (>) 24 or less than (<) 12. Systolic BP greater than (>) 180 or less than (<) 90. Diastolic BP greater than (>) 90 or less than (<) 60. O2 Sat (percent) less than (<) 90. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely;				
22. Goals/Rehabilitation Potential/Discharge Plans The patient will have no hospitalizations during the episode. The Patient/Caregiver will verbalize understanding of individualized emergency plan by the end of the episode. 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. Patient skin integrity will remain intact during this episode. Respiratory status will improve with reduced shortness of breath and improved lung sounds by the end of the episode. Patient will be free from signs and symptoms of respiratory distress during the episode. PT WILL ACHIEVE A STABLE BP AS EVIDENCED BY VITAL SIGNS WITHIN NORMAL LIMITS WITHIN 60				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Vaishali Patel RN 06/2/2016			25. Date HHA Received Signed POT	
24. Physician's Name and Address Ketha, Sumana MD 2925 Skyway Cir N Irving TX 75038 Phone: (972) 675-7313 Fax: (972) 675-7310 NPI: 1962447805		26. Physician Certification Statement I 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. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I estimate the duration of continued Home Health services for this patient to be 60 DAYS (Days/weeks/Months)		
27. Attending Physician's Signature and Date Signed  Electronically signed by Ketha, Sumana M.D. on 07/01/2016		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

1. Patient's HI Claim No. 644015347M	2. Start Of Care Date 04/05/2016	3. Certification Period From: 06/04/2016 To: 08/02/2016	4. Medical Record No. GAV347M	5. Provider No. 679445
6. Patient's Name: GARZA, VIRGILIO		7. Providers Name Family Connections Home Health Care		
10. Medications CETIRIZINE 10 MG ORAL TABLET 1 TAB EVERY EVENING FOR ITCHING PO N FINASTERIDE 5 MG ORAL TABLET 1 TAB Q DAY PO N METOPROLOL TARTRATE 100 MG ORAL TABLET 1 TAB TWICE A DAY PO N WARFARIN 5 MG ORAL TABLET 1/2 TAB MONDAY AND WEDNESDAY PO N WARFARIN 5 MG ORAL TABLET 1 TAB TUE, THURSDAY, FRIDAY, SATURDAY AND SUNDAY PO N ASPIRIN 81 MG ORAL TABLET 1 TAB ONCE A DAY PO N CORTIZONE-10 TO THE AFFECTED AREA TOP N				
13. Other Diagnoses G89.4 Chronic pain syndrome Z95.1 Presence of aortocoronary bypass graft Z87.891 Personal history of nicotine dependence K46.9 Unspecified abdominal hernia without obstruction or gangrene Z95.2 Presence of prosthetic heart valve Z79.01 Long term (current) use of anticoagulants N42.9 Disorder of prostate, unspecified				
14. DME and Supplies Covers				
15. Safety Measures Precautions, Keep Pathway Clear, Safety in ADLs, Slow Position Change, Standard Precautions/Infection Control, Support During Transfer and Ambulation, Use of Assistive Devices, Instructed on mobility safety, Instructed on disaster/emergency plan, Instructed on safety measures				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) Unable to safely leave home unassisted; SN to develop individualized emergency plan with patient. SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. 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, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. SN to assess O2 saturation on room air (freq) Q VISIT. SN to instruct the Patient/Caregiver on factors that contribute to SOB. 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. Report to physician O2 saturation less than 90%. SN to assess/instruct on signs & symptoms of pulmonary complications. SN to perform weekly weights. SN TO ASSESS ALL BODY SYSTEMS. SN TO ASSESS CARDIOVASCULAR STATUS FOR HEART SOUNDS, EDEMA, PERIPHERAL CIRCULATION, ANGINA. SN TO ASSESS ALL BODY SYSTEMS. SN TO ASSESS KNOWLEDGE OF MEDICATION REGIMEN AND DEFICITS, TEACH PT/CG BP MEDICATIONS, TO INCLUDE PURPOSE, ACTION S/E AND SAFETY MEASURES. SN TO INSTRUCT ON NEW AND CHANGED MEDICATIONS AND AREAS WHERE KNOWLEDGE DEFICIT NOTED. SN TO TEACH DISEASE PROCESS OF HTN, TO INCLUDE PATHOPHYSIOLOGY, S/SX, TREATMENT AND EXACERBATION. INSTRUCT ON 2GM NA DIET, IMPORTANCE OF KEEPING DAILY BP LOG, AND HEALTHY EATING TIPS (FOOD CHOICES) AND ALL AREAS WHERE KNOWLEDGE DEFICIT NOTED. SN TO INSTRUCT ON NON-PHARMACOLOGICAL MANAGEMENT OF HTN. SN TO ASSESS PAIN LEVEL AND EFFECTIVENESS OF PAIN MEDICATION EVERY VISIT, REPORT PAIN LEVEL >5 TO MD. INSTRUCT ON ENERGY CONSERVATION, INCONTINENT CARE AND HOME SAFETY MEASURES. SN to instruct Patient/Caregiver on HH COUMADIN diet. SN to perform a neurological assessment each visit. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device 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. 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. SN to				
27a. Signature of Physician:  Electronically signed by Ketha, Sumana M.D. on			27b. Date: 07/01/2016	
23. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Vaishali Patel RN			Date 6/2/2016	

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 644015347M	2. Start Of Care Date 04/05/2016	3. Certification Period From: 06/04/2016 To: 08/02/2016	4. Medical Record No. GAV347M	5. Provider No. 679445	
6. Patient's Name: GARZA, VIRGILIO		7. Providers Name Family Connections Home Health Care			
<p>21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) instruct the Patient/Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants.</p>					
<p>22. Goals/Rehabilitation Potential/Discharge Plans DAYS. PT WILL HAVE ADEQUATE WORKING KNOWLEDGE OF DISEASE PROCESS, PATHO, S/SX, TX, AND EXACERBATION WITHIN 60 DAYS. PT WILL BE ABLE TO LIST 2 OF 4 USES OF BP MEDICATION WITHIN 60 DAYS. PT WILL BE ABLE TO LIST 1 OF 3 S/E OF BP MEDICATION WITHIN 60 DAYS. PT WILL BE ABLE TO STATE IMPORTANCE OF 2 GM SODIUM DIET AND NON-PHARMACOLOGICAL MANAGEMENT OF HTN WITHIN 60 DAYS. PT WILL BE ABLE TO LIST 3 OF 5 FOODS WITH LOW SALT CONTENT WITHIN 60 DAYS. PT WILL HAVE ADEQUATE WORKING KNOWLEDGE OF PAIN MANAGEMENT, ENERGY CONSERVATION AND HOME SAFETY MEASURE WITHIN 60 DAYS. REHAB POTENTIAL: GOOD FOR GOALS STATED ABOVE. DC PLANS: PATIENT WILL BE DISCHARGED WHEN GOALS ARE MET OR ALTERNATIVE CARE HAS BEEN ARRANGED. . Patient will maintain HH COUMADIN diet compliance during the episode. Neuro status will be within normal limits and free of S&S of complications or further deterioration. 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: Good for stated goals. Discharge Plan: Patient to be discharged to the care of Physician. Patient to be discharged to the care of Caregiver. Discharge when caregiver willing and able to manage all aspects of patient's care. Discharge when goals met.</p>					
<p>27a. Signature of Physician:  Electronically signed by Ketha, Sumana M.D. on</p>					<p>27b. Date: 07/01/2016</p>
<p>23. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Vaishali Patel RN</p>				<p>Date 6/2/2016</p>	