

1615 N. Hampton Rd. Suite 130
Desoto, TX 75115
(P) 972-296-1901
(F) 972-296-5590

**PROSPERITY
HEALTH SERVICES**

Fax

To: Dr. Sumana Ketha From: LINDA PAIZ
Fax: 972-675-7310 Pages: 6
Phone: _____ Date: 8/15/16
Re: Home Health Orders cc: _____

(Urgent) (Please Reply)

☐ Comments:

Willie Goran
Recent Order - 7/28/16
485 Aug. - Sept 2016

Bernard Mathis
485 - Aug. - Oct. 2016

Important Notice

This message is intended only for the use of the individual to which it is addressed. It may contain information that is privileged, confidential and exempt from disclosure under law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, notify us immediately by telephoning our office.

**ORDERS MUST BE SIGNED AND RETURNED
WITHIN 30 DAYS**

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 HI Claim No. 462769928A	2. Start of Care Date 04/04/2016	3. Certification Period From: 08/02/2016 To: 09/30/2016	4. Medical Record No. 115-1	5. Provider No. 453189
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6. Patient's Name and Address GOVAN, WILLIE 760 MEADOW PARKWAY DESOTO, TX 75115 (214) 207-7918	7. Provider's Name, Address and Telephone PROSPERITY HEALTH SERVICES, LLC. 1615 N. HAMPTON RD., STE. 130 DESOTO, TX 75115-2333 (972) 296-1901 Fax: (972) 296-5590
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8. Date of Birth 12/31/1942	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged SIMVASTATIN 40MG 1 TAB PO HS HCTZ 25MG 1/2 TAB PO QAM SYSTANE OPTH ULTRA 1 QTT BID BOTH EYES LISINAPRIL 10MG 1 TAB PO QD LEVOTHYROXINE 100MCG 1 TAB PO QD MECLIZINE 25MG 1 TAB PO PRN DIZZINESS ZYRTEC 1 TAB PO QD FLUTICASONE NASAL SP 50MCG 2 SPRAYS QD Q-VAR NFA 40 MCG 2 PUFFS PO PRN SOB PRO AIR INHALER 2 PUFFS PRN SOB
11. ICD-10-CM Principal Diagnosis I10 Essential (primary) hypertension	Date	(Contd. 487)
12. ICD-10-CM Surgical Procedure	Date	
13. ICD-10-CM Other Pertinent Diagnoses E039 Hypothyroidism, unspecified H268 Other specified cataract M1990 Unspecified osteoarthritis, unspecified site E785 Hyperlipidemia, unspecified	Date	

14. DME and Supplies GLOVES, THERMOMETER COVERS	15. Safety Measures: FALL PRECAUTIONS, ANTICOAGULATION, INFECTION CONTROL/STANDARD
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16. Nutritional Req. NAS	17. Allergies: ASA
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18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 3 <input type="checkbox"/> Contracture 4 <input type="checkbox"/> Hearing 5 <input type="checkbox"/> Paralysis 6 <input checked="" type="checkbox"/> Endurance 7 <input checked="" type="checkbox"/> Ambulation 8 <input type="checkbox"/> Speech 9 <input type="checkbox"/> Legally Blind A <input checked="" type="checkbox"/> Dyspnea With Minimal Exertion B <input checked="" type="checkbox"/> Other (Specify) USE OF CANE, SHUFFLED GAIT	18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 2 <input type="checkbox"/> Bedrest BRP 3 <input checked="" type="checkbox"/> Up As Tolerated 4 <input type="checkbox"/> Transfer Bed/Chair 5 <input type="checkbox"/> Exercises Prescribed 6 <input type="checkbox"/> Partial Weight Bearing 7 <input type="checkbox"/> Independent At Home 8 <input type="checkbox"/> Crutches 9 <input checked="" type="checkbox"/> Cane A <input type="checkbox"/> Wheelchair B <input type="checkbox"/> Walker C <input type="checkbox"/> No Restrictions D <input type="checkbox"/> Other (Specify)
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19. Mental Status: 1 <input checked="" type="checkbox"/> Oriented 2 <input type="checkbox"/> Comatose 3 <input checked="" type="checkbox"/> Forgetful 4 <input type="checkbox"/> Depressed 5 <input type="checkbox"/> Disoriented 6 <input type="checkbox"/> Lethargic 7 <input type="checkbox"/> Agitated 8 <input type="checkbox"/> Other	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
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21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SKILLED NURSE TO EDUCATE ON HYPERTENSION, HYPOTHYROIDISM, CATARACT, OSTEOARTHRITIS, HYPERLIPIDEMIA, CHRONIC PAIN AND GLAUCOMA. SN: 1W9

SN TO ASSESS VITAL SIGNS AND PERFORM GENERAL SYSTEMS ASSESSMENT. VITAL SIGNS PARAMETERS OF SBP > 170 < 90 OR DBP > 100 < 50; PULSE < 55 OR > 100; RESP < 14 OR > 28; TEMP < 96.0 F OR > 100.5 F. SKILLED NURSE TO ASSESS ALL BODY SYSTEMS, KNOWLEDGE AND MANAGEMENT OF DISEASE PROCESS AND ITS ASSOCIATED CARE AND TREATMENT, MEDICATION REGIMEN KNOWLEDGE, SIDE EFFECTS AND SIGNS AND SYMPTOMS OF COMPLICATIONS NECESSITATING MEDICAL ATTENTION. SN TO ASSESS DIET, NUTRITIONAL INTAKE, PAIN MANAGEMENT AND SAFETY AND EMERGENCY MEASURES TO INCLUDE EMERGENCY CONTACT INFORMATION AND PATIENT EMERGENCY PLAN.

SKILLED NURSE TO INSTRUCT PATIENT/CAREGIVER ON STANDARD PRECAUTIONS, KNOWLEDGE DEFICIT RELATED TO ACTIVE DISEASE PROCESS, INFECTION CONTROL AND MEDICATION REGIMEN INCLUDING: DOSAGE, SIDE EFFECTS, NAME, ROUTE, FREQUENCY, DESIRED ACTION AND ADVERSE REACTIONS.

22. Goals/Rehabilitation Potential/Discharge Plans PATIENT'S BLOOD PRESSURE TO BE WITHIN NORMAL LIMITS BY 9/30/2016. THE PATIENT'S PAIN WILL BE < 2 ON A SCALE OF 0 - 10 BY THE END OF THE CERT PERIOD. THE PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF THE DISEASE PROCESS AND ALL ASPECTS OF ASSOCIATED CARE THIS CERT PERIOD. THE PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF ALL MEDICATIONS TO INCLUDE THEIR ACTION/DOSAGE/ SIDE EFFECTS WITHIN THIS CERT PERIOD.

23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>[Signature]</i>	25. Date HHA Received Signed POT
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24. Physician's Name and Address SUMANA KETHA 2925 SKYWAY CIRCLE N. IRVING, TX 75038 (972) 675-7313 Fax: (972) 675-7310 NPI: 1962447805 UPIN: G86756	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.
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27. Attending Physician's Signature and Date Signed <i>[Signature]</i> Electronically signed by Ketha, Sumana M.D. on 11/03/2016	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.
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ADDENDUM TO:☒ **PLAN OF TREATMENT**☐ **MEDICAL UPDATE**

1. Patient HI Claim No. 462769928A	2. Start of Care Date 04/04/2016	3. Certification From: 08/02/2016 To: 09/30/2016	4. Medical Record No. 115-1	5. Provider 453189
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6. Patient's Name GOVAN, WILLIE	7. Provider's Name PROSPERITY HEALTH SERVICES, LLC.
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8. Item
No.

13.	ICD-10-CM	Other Pertinent Diagnoses	Date
	G8929	Other chronic pain	
	H409	Unspecified glaucoma	

10.

TYLENOL ES 500MG 1 TAB PO PRN
TRAMADOL 50MG 1 TAB PO BID PRN PAIN
ROBITUSSIN DM 1 TSP PO PRN COUGH
ALBUTEROL MED NEB 0.83%/2.5MG 1 PUFF Q4HRS PRN SOB

15.

PRECAUTIONS, POST WARFARIN USE.

21.

Orders - Continued

INSTRUCT PATIENT/CAREGIVER ON INTERVENTIONS TO MONITOR AND MITIGATE PAIN. SKILLED NURSE TO INSTRUCT PATIENT/CAREGIVER ON INTERVENTIONS TO REDUCE THE RISK OF FALLS SUCH AS ENVIRONMENTAL CHANGES, STRENGTHENING EXERCISES, USE OF SAFETY DEVICES AND NOTIFY PHYSICIAN OF SIGNS AND SYMPTOMS REQUIRING MEDICAL ATTENTION. INSTRUCT ON DIET COMPLIANCE, SIGNS AND SYMPTOMS, NUTRITIONAL INTAKE AND NOTIFY PHYSICIAN OF SIGNS AND SYMPTOMS REQUIRING MEDICAL ATTENTION. INSTRUCT PATIENT/CAREGIVER OF MEASURES TO RECOGNIZE CARDIAC DYSFUNCTION AND RELIEVE COMPLICATIONS. SN TO ASSESS//INSTRUCT ON NEUROLOGICAL STATUS, MUSCULO-SKELETAL STATUS, RESPIRATORY STATUS AND INSTRUCT PATIENT/CAREGIVER ON METHODS TO RECOGNIZE PULMONARY AND CARDIAC DYSFUNCTIONS AND RELIEVE COMPLICATIONS.

SN TO PERFORM PAIN MANAGEMENT AND REPORT PAIN LEVEL > 4 ON A SCALE OF 0 - 10. SN MAY ASSIST WITH SETTING UP AND ADMINISTERING MEDICATION AS NEEDED. SN MAY PERFORM O2 SAT PRN PER PULSE OX AS PART OF COMPREHENSIVE ASSESSMENT OR PRN SIGNS AND SYMPTOMS OF INADEQUATE OXYGENATION AND NOTIFY PHYSICIAN OF SIGNS AND SYMPTOMS REQUIRING MEDICAL ATTENTION. NOTIFY PHYSICIAN OF O2 SAT < 90%. SN MAY WEIGH PATIENT EACH VISIT AND REPORT WEIGHT GAIN OF 5 LBS OR MORE. SKILLED NURSE TO PERFORM VITAL SIGNS EVERY VISIT AND REPORT ABNORMAL PARAMETERS TO PHYSICIAN, WHERE INDICATED. SN MAY PERFORM ADDITIONAL 1 - 2 VISITS PRN. MAY ACCEPT ORDERS FROM OTHER PHYSICIANS.

22.

Goals - Continued

THE PATIENT'S SAFETY WILL BE ENHANCED THROUGHOUT THE HOME CARE SERVICE AS EVIDENCED BY NO FALLS/COMPLICATIONS WITHIN THE 60 DAY CERT PERIOD.

REHABILITATION POTENTIAL: FAIR

DISCHARGE PLAN:

THE CLIENT WILL BE DISCHARGED TO SELF/FAMILY UNDER MD SUPERVISION WHEN ALL GOALS ARE MET AND CONDITION STABLE.

9. Signature of Physician *S. Ketha* Electronically signed by Ketha, Sumana M.D. on

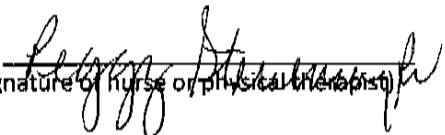
10. Date 11/03/2016

11. Optional Name/Signature of Nurse/Therapist

12. Date

PHYSICIAN'S TELEPHONE VERBAL ORDER

Prosperity Home Health Agency

To: Dr. Sumana Ketha
(Name of physician)Date: July 28, 2016From: 
(Signature of nurse or physical therapist)Patient: Willie Govan
(Name of patient)

WE HAVE RECEIVED YOUR TELEPHONE VERBAL ORDERS FOR THE ABOVE MENTIONED PATIENT. THESE ORDERS ARE LISTED BELOW FOR YOUR REVIEW. PLEASE SIGN AND RETURN TO OUR OFFICE IN THE ENCLOSED ENVELOPE OR FAX TO 972-296-5590 WITHIN 48 HOURS.

THANK YOU!

ORDERS:

Please recertify patient to Home Health for cert period August 2, 2016 through September 30, 2016

Skilled Nurse to assess and evaluate all systems, including blood pressure monitoring, educating on disease process, treatment plan, medication regimen, diet, signs and symptoms of disease process and safety measures.

Date 11/03/2016

S. Ketha Electronically signed by Ketha, Sumana M.D. on
Physician's Signature