


HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 448607490C2		2. Start Of Care Date 10/23/2014		3. Certification Period From: 12/22/2014 To: 02/19/2015		4. Medical Record No. IHHC-127		5. Provider No. 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@integris-hhc.com				
8. Date of Birth 10/19/1983		9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged THORAZINE 100 MG ORAL TABLET ONE TAB THREE TIMES DAILY By mouth (PO) N AMLODIPINE 10 MG ORAL TABLET daily By mouth (PO) U TRAZODONE 100 MG ORAL TABLET 1 tab at bedtime prn By mouth (PO) U HALOPERIDOL 10 MG ORAL TABLET 10 mg twice daily By mouth (PO) U DIPHENHYDRAMINE 50 MG ORAL CAPSULE 50 mg QID By mouth (PO) C DEPAKOTE DR 1000 MG 1000 MG TWICE DAILY By mouth (PO) U					
11. ICD-9-CM 715.09		Principal Diagnosis General osteoarthritis		Date 12/18/2014					
12. ICD-9-CM		Surgical Procedure		Date					
13. ICD-9-CM 401.1 728.87 724.3 333.99		Other Pertinent Diagnoses Benign hypertension Muscle weakness-general Sciatica Extrapyramidal dis NEC		Date 12/18/2014 12/18/2014 12/18/2014 12/18/2014					
14. DME and Supplies Alcohol Pads, Exam Gloves, Probe Covers, Tape					15. Safety Measures: Emergency Plan Developed, Fall Precautions, Keep Pathway Clear.				
16. Nutritional Req. Heart Healthy.					17. Allergies: NKA (Food/Drugs/Latex/Environment)				
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 type="checkbox"/> Endurance A <input 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 type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech social functioning,					4 <input type="checkbox"/> Transfer Bed/Chair 9 <input 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 type="checkbox"/> Forgetful		5 <input type="checkbox"/> Disoriented 7 <input checked="" 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 checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good		5 <input type="checkbox"/> Excellent			
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN Frequency: 1W9. PT Frequency: Physical therapist to evaluate and submit plan of treatment. MSW Frequency: EVAL AND CONSULT. MSW to assess psychosocial needs, environment and assist with community referrals and resources every 60 days. SN to notify MD of: Temperature greater than (>) 100.5 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: Unable to safely leave home unassisted; Unsafe to leave home due to cognitive or psychiatric impairments; SN to develop individualized emergency plan with patient. SN to assess pain level, report to physician if patient experiences pain level not acceptable to patient, pain level greater than a 5 out of 10 pain scale, and educate and gauge effectiveness of pain relief measures instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to assess skin for breakdown every visit.									
22. Goals/Rehabilitation Potential/Discharge Plans 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. Patient will verbalize an understanding of energy conserving measures by end of									
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Monica Todd RN 12/18/2014						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) 247-3060 Fax: (888) 841-3651					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  Electronically signed by Ketha, Sumana M.D. on 12/30/2014					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 ServicesForm Approved
OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 448607490C2	2. Start Of Care Date 10/23/2014	3. Certification Period From: 12/22/2014 To: 02/19/2015	4. Medical Record No. IHHC-127	5. Provider No. 747682
6. Patient's Name: Alsip, Jeromy		7. Providers Name Integris Home Health Care, LLC		
10. Medications LORAZEPAM 2 MG ORAL TABLET 1 tab QID By mouth (PO) U INVEGA SUSTENNA 234 MG/1.5 ML INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE prn Intramuscular (IM) U				
13. Diagnoses 307.42 / Persistent insomnia / 12/18/2014 296.90 / Episodic mood disord NOS / 12/18/2014 V58.69 / Long-term use meds NEC / 12/18/2014				
15. Safety Measures Safety in ADLs, Slow Position Change, Standard Precautions/Infection Control, Instructed on mobility safety, Instructed on disaster/emergency plan, Instructed on safety measures				
18.A. Functional Limitations concentration ambulation challenged with EPS				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN to instruct patient on energy conserving measures including frequent rest periods, small frequent meals, avoiding large meals/overeating, controlling stress. SN to perform weekly weights. SN to instruct patient on daily weight self-monitoring program, and to report weight gain of 2-3lbs/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 instruct Patient/Caregiver on HEART HEALTHY diet. SN to assess patient for diet compliance. SN to perform a neurological assessment each visit. 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. 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 instruct the Patient/Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants.				
22. Goals/Rehabilitation Potential/Discharge Plans the episode. Patient to verbalize the importance and demonstrate proper foot wear use and daily foot /lateral leg exams. The Patient/Caregiver will verbalize understanding of symptoms of cardiac complications and when to call 911 by 02/15/2015. 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. Patient's community resource needs will be met with assistance of social worker. 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. The Patient/Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by 02/14/2015. Eye and Dental exam prior to the end of the episode. Rehab Potential: Fair for stated goals. Discharge when goals met.				
9. Signature of Physician:  Electronically signed by Ketha, Sumana M.D.			10. Date: 12/30/2014	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN			12. Date 12/18/2014	