PROXIMAL HOME HEALTHCARE

Phone: 214-253-2558
Fax: 214-253-2559

Fax

To: Ketha, Sumana MD	**From: Osas Erhabor RN/BSN**
Fax: (972) 675-7310	**Pages: 5**
Re:	**Date: November 08, 2016**

PLEASE SIGN AND FAX BACK ASAP!
THANKS
OSA RN/BSN

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's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
453302820A	09/01/2016	From: 10/31/2016 To: 12/29/2016	PHCC030	747805

6. Patient's Name and Address
WALKER, WILKIE D.
7835 MILITARY PRKWY APT 217
Dallas, TX 75227
(214) 809-0417

7. Provider's Name, Address and Telephone Number
Proximal Home Healthcare Inc
8330 LYNDON B JOHNSON FRWY Suite 365
Dallas, TX 75243
Phone: (214) 253-2558 | Fax: (214) 432-5497
Email: proximal.health@att.net

8. Date of Birth 06/10/1925

9. Sex [X] M [ ] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged
HYDROCHLOROTHIAZIDE 25 MG ORAL TABLET DAILY PO N
AMLODIPINE BESYLATE 2.5MG DAILY ORAL N

11.ICD- 10-CM	Principal Diagnosis		Date
I10	Essential (primary) hypertension	E	10/26/2016
12.ICD- 10-CM	Surgical Procedure		Date
13.ICD- 10-CM	Other Pertinent Diagnoses		Date
M19.90	Unspecified osteoarthritis, unspecified site	E	10/26/2016

14. DME and Supplies
Cane, Exam Gloves, Probe Covers

15. Safety Measures:
Fall Precautions, Keep Pathway Clear, Safety in ADLs, Standard

16. Nutritional Req. Regular. Heart Healthy. Low Cholesterol. Low Fat.

17. Allergies: NKA (Food/Drugs/Latex/Environment)

18.A. Functional Limitations
1 [ ] Amputation; 2 [X] Bowel/Bladder (Incontinence); 3 [ ] Contracture; 4 [X] Hearing; 5 [ ] Paralysis; 6 [X] Endurance; 7 [X] Ambulation; 8 [ ] Speech; 9 [ ] Legally Blind; A [X] Dyspnea With Minimal Exertion; B [ ] Other (Specify)

18.B. Activities Permitted
1 [ ] Complete Bedrest; 2 [ ] Bedrest BRP; 3 [X] Up As Tolerated; 4 [ ] Transfer Bed/Chair; 5 [X] Exercises Prescribed; 6 [ ] Partial Weight Bearing; 7 [ ] Independent At Home; 8 [ ] Crutches; 9 [X] Cane; A [ ] Wheelchair; B [ ] Walker; C [ ] No Restrictions; D [ ] Other (Specify)

19. Mental Status: 1 [X] Oriented; 2 [ ] Comatose; 3 [X] Forgetful; 4 [X] Depressed; 5 [ ] Disoriented; 6 [ ] Lethargic; 7 [ ] Agitated; 8 [ ] Other

20. Prognosis: 1 [ ] Poor; 2 [ ] Guarded; 3 [X] Fair; 4 [ ] Good; 5 [ ] Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
SN Frequency: 1w9.
Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; Unsafe to leave home due to cognitive or psychiatric impairments; SN to notify MD of: Temperature greater than (>) 100.5 or less than (<) 95.9F. 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.

CARDIOPULMONARY: SN to perform weekly weights. SN to instruct the Patient/Caregiver on measures to recognize cardiac dysfunction and relieve complications. 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.

MEDICATION: SN to assess caregiver filling medication box to determine if caregiver is preparing correctly. SN to determine if the

22. Goals/Rehabilitation Potential/Discharge Plans
CARDIOPULMONARY: 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. Patient and caregiver will verbalize an understanding of factors that contribute to shortness of breath by: EOE. Patient will verbalize an understanding of energy conserving measures by: EOE. The Patient/Caregiver will verbalize understanding of symptoms of cardiac complications and when to call 911 by EOE. Patient will maintain heart healthy diet compliance during the

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by: Mike Olufemi RN

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ketha, Sumana MD
2925 Skyway Cir N
Irving TX 75038
Phone: (972) 639-5838 | 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. 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.

27. Attending Physician's Signature and Date Signed

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 Services

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ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
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6. Patient's Name:	7. Providers Name
WALKER, WILKIE D.	Proximal Home Healthcare Inc

10. Medications

CYANOCOBALAMIN 1000 MCG ORAL TABLET DAILY N
DONEPEZIL HYDROCHLORIDE 5MG DAILY ORAL N
VITAMIN B-12 1000 MCG ORAL TABLET DAILY N
CLONIDINE 0.2 MG ORAL TABLET PRN FOR SBP>160 BID N
TYLENOL 500 MG ORAL TABLET Q6HRS PRN FOR PAIN N
DOCUSATE SODIUM 100 MG ORAL CAPSULE PRN FOR CONSTIPATION N
LEVOBUNOLOL HYDROCHLORIDE, OPHTHALMIC 0.5% BOTH EYES EYE ONE GTT BID N
TRAVATAN 0.004% OPHTHALMIC SOLUTION 2.5ML BOTH EYE ONE GTT BID N
LISINOPRIL 20 MG ORAL TABLET DAILY N

13. Other Diagnoses

N40.0 Enlarged prostate without lower urinary tract symptoms (E)
G30.9 Alzheimer's disease, unspecified (E)
R39.81 Functional urinary incontinence (E)

15. Safety Measures

Precautions/Infection Control, Instructed on safe utilities management, Instructed on mobility safety

16. Nutritional Requirements

Low Sodium. No Added Salt.

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

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 establish reminders to alert patient to take medications at correct times.

PAIN: SN to instruct patient to take pain medication before pain becomes severe to achieve better pain control. 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 6, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities.

SAFETY/MOBILITY: SN to perform a neurological assessment each visit. SN to assess/instruct on pain management, proper body mechanics and safety measures. SN to assess for patient adherence to appropriate activity levels. SN to assess patient's compliance with home exercise program. 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.

22. Goals/Rehabilitation Potential/Discharge Plans

episode.

MEDICATION: The Patient/Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by EOE.

PAIN: PT/CG will verbalize knowledge of pain medication regimen and pain relief measures 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.

SAFETY/MOBILITY: Patient will have increased mobility, self care, endurance, ROM and decreased pain by the end of the episode. Patient will maintain optimal joint function, increased mobility and independence in ADL's by the end of the episode. Patient's strength, endurance and mobility will be improved. 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: Fair for stated goals.Discharge Plan:Patient to be discharged to the care of Physician. Discharge when

27a. Signature of Physician:	27b. Date:
S. Ketha Electronically signed by Ketha,Sumana M.D. on	11/16/2016
23. Optional Name / Signature of Nurse / Therapist	Date
Electronically Signed by: Mike Olufemi RN	10/26/2016

Form CMS-487 (U4)(4-87)

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WALKER, WILKIE D.	Proximal Home Healthcare Inc

22. Goals/Rehabilitation Potential/Discharge Plans
caregiver willing and able to manage all aspects of patient's care.

27a. Signature of Physician:	27b. Date:
S. Ketha Electronically signed by Ketha,Sumana M.D. on	11/16/2016
23. ~~Optional Name~~ Signature of Nurse / Therapist	Date
Electronically Signed by: Mike Olufemi RN	10/26/2016

Form CMS-487 (U4)(4-87)

Proximal Home Healthcare Inc
8330 Lyndon B Johnson FrwySuite 365
Dallas, TX 75243
Phone: (214) 253-2558 | Fax: (214) 432-5497

PHYSICIAN ORDER

Patient: Walker, Wilkie D
7835 Military Prkwy
Apt 217
Dallas, Tx 75227
(214) 809-0417
HIC: 453302820A
MRN: PHCC030
DOB: 6/10/1925

Physician: Ketha, Sumana MD
2925 Skyway Cir N
Irving, Tx 75038
Phone: (972) 639-5838 | Fax: (972) 675-7310
NPI: 1962447805

Order Date: 10/25/2016 **Order #:** 34520279 **Episode Associated:** 10/31/2016—12/29/2016
Allergies: NKA (Food/Drugs/Latex/Environment)
Summary: Re-Cert Order

Episode: 10/31/2016 to 12/29/2016
Orders:
Re-Certify for Home Health Care Services
Re-Certify to Proximal Home Health Inc
I certify/recertify that this patient is confined to his/her home
and needs one or more of the following:
Skilled Nursing Care
The patient has had a face to face encounter by me and is under my care. I have authorized the services on this plan of care and will periodically review the plan

[x] Order read back and verified.

Clinician Signature: **Date:**
Electronically Signed by: Osasogie Erhabor RN 10/25/2016

Physician Signature: **Date:**
S. Ketha Electronically signed by Ketha,Sumana M.D. on 11/16/2016