TPHC
Texas Physicians House Calls
[illegible] Way North, Irving, TX 75038, Tel: 972 675 7313 Fax: 972 675 7310
www.texashousecalls.com email: hhsupport@texashousecalls.com

Documentation of Face-to-Face Encounter

Patient name and Identification Dorothy Adams

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: (insert date that visit occurred)

10 / 24 / 2014
Month Day Year

This is face to face from your office after NP saw Patient on 10/24/14.

Is Patient Home Bound or Can't Drive (Circle your choice) (Y) N

Is Home Health Care Needed (Circle your choice) (Y) N

Does Patient have reliable other Primary Care Physician (Circle your choice) Y N

Is House Visit Needed (Circle your choice) (Y) N

If Yes (Circle Next Visit in Days approximately) (30) 60 90 Other ____

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

Alzheimers DZ, HTN, Dementia, DMZ, Chronic UTI's

I certify that, based on my findings, the following services are medically necessary home health services:

X Nursing
___ Physical Therapy
___ Occupational Therapy
___ Speech-language Pathology

To provide the following care/treatments: (Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):

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

SN needed due to Alzheimers Dz and Behavioral sx.

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because Patient is home bound due to dementia + alzheimer's DZ, and cannot be left unattended due to wandering behavior + poor cognition

Nurse Practitioner Signature [signature] Date 10-24-14

Physician's Signature [signature]

Printed Name Sumana Vetha Date of Signature 10/27/14

Our Saviour Healthcare Services Inc

7205 High Point Drive - Sachse, TX - 75048
❖ Phone: 469-235-1576 ❖ Fax: 469-814-0990

PHYSICIAN START OF CARE/RECERTIFICATION ORDER

Order Date: 10/15/2014 ☑ START OF CARE ☐ RECERTIFICATION

Patient Name:	Medical Record #:
Adams Dorothy	OS0929

Physician Name:	Phone #:	Fax #:
Dr Sumana Kethu	(972)675-7313	(972)675-7310

Please sign, date and return these orders to the address or fax number at the top of this page.

Thank you for your prompt attention.

Sincerely,

SN's Name: Cindy Adams 10/29/2014

ORDERS

☑ Admit patient to home health for certification period: 10/16/14 to 12/14/14
to assess/evaluate, provide skilled care, for continued monitoring teaching and/or exacerbation of:

☐ Recert patient to home health for certification period: _____ to _____
to assess/evaluate, provide skilled care, for continued monitoring teaching and/or exacerbation of:

Discipline(s) to follow the following frequencies:

SN: 2WK1, 1WK 8 ending week of 12/07/14

HHA: 2WK1, 5WK, 8 ending week of 12/07/14

PT:

OT:

ST:

MSW:

Allergies:

SIGNATURES

Signature of Clinician: Cindy Adams **Date:** 10/15/2014

Signature of Physician: Sethu **Date:** 10/29/14

PTHC04/11

Our Saviour Healthcare Services, Inc.
7205 High Point Dr Sachse TX 75048-2160
Phone 4692351576 Fax 4698140990

PHYSICIAN ORDER

Patient's Name:	Dorothy Adams	**MRN:**	OS0929
Patient's Ctrl No.:	**Patients's DoB:** 09/04/1929	**Date:**	10/27/2014
Patient's HIC No.:	450426255A	**Time:**	1:00 pm
Physician Name:	KETHA SUMANA MD	**Phone:**	9726757313
Physician	2925 SKYWAY CIRCLE IRVING TX 75038	**Fax:**	9726757310

- [X] Start of Care
- [ ] Plan of Care Change
- [ ] Progress Report
- [ ] Medication Change
- [ ] Discharge
- [ ] Recertification
- [ ] Frequency Change
- [X] Post Hospital
- [ ] Medical Supplies
- [ ] Other

Order

SN to resume all home health care services. SN frequency to read 1wk8 .Physical therapist to resume care . Physical therapist to assess, evaluate and treat and Home health aide to resume aide care, HHA frequency to read 3wk8.

Nurse Signature: Digitally Signed by: AKANNA GERTRUDE, RN **Date:** 10/27/2014

Physician Signature: **Date:**

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./NPI
450426255A	10/21/2014	From: 10/21/2014 To: 12/19/2014	OS0929	747641/1326274978

6. Patients Name and Address
Dorothy Adams
1407 BRAEWOOD PL
DUNCANVILLE TX 75137 9723028702

7. Provider's Name, Address and Phone Number
Our Saviour Healthcare Services, Inc.
7205 High Point Dr Sachse TX 75048-2160
Phone: 4692351576 Fax: 4698140990

8. Date Of Birth 09/04/1929 **9. Sex** M [X] F

11. ICD-9-CM	Principal Diagnosis	Date
250.02	Diabetes mellitus without E	

12. ICD-9-CM	Surgical Diagnosis	Date

13. ICD-9-CM	Other Pertinent Diagnosis	Date
357.2	Polyneuropathy In Diabete E	
781.2	Abnormality Of Gait E	
728.87	Muscle Weakness (Generali E	
298.0	Depressive Type Psychosis E	

10. Medication: Dose/Frequency/Route (N)ew (C)hange
Metformin HCl 1000MG 1tab Tablet Oral twice a day diabetes (L)
Amlodipine 10MG 1tab Tablet Oral once a Day HTN (L)
Quetiapine Fumarate 25MG 1TAB Tablet Oral twice a day Psychosis (L)
Tylenol Arthritis 650MG 2tabs Tablet Oral every 6 hours prn pain (L)

14. DME and Supplies Alcohol Pads,Chemstrips,Probe Covers,Diabetic Supplies,Exam Gloves,

15. Safety Measures Slow Position Change,Use of Assistive Devices,Instructed on Emergency

16. Nutritional req. Low-Fat Diet,Low Cholesterol Diet,1800 ADA diet,2gm NA diet,

17. Allergies NKDA

18.A Functional Limitations

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

18.B Activities Permitted

1	Complete Bed Rest	6	Partial Weight Bearing	A	[X] Wheelchair
2	BedRest BRP	7	Independent At Home	B	[X] Walker
3	[X] Up As Tolerated	8	Crutches	C	No Restriction
4	[X] Transfer Bed/Chair	9	Cane	D	Other Specify
5	Exercise Prescribed				

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

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

21. Orders For Disciplines and Treatment (Specify Amount/Frequency/Duration)
SN frequency 1wk9, HHA Frequency 3wk1, 5wk8
SN to perform skilled assessment of the body system with vital signs at every visit, SN to assess all body systems. V/S parameter to report to MD-BP> 160/90 or 90/60, HR > 100 or <60, Resp. >24 or <12, Temp> 100.5 or <96. SN to assess pt's cardiac status for chest pain, peripheral edema, pulse irregularities, peripheral circulation and angina. Assess musculoskeletal status for level of joint pain, effectiveness of current pain regimen and report pain level greater than 5 to MD. SN also to assess respiratory status for dyspnea, abnormal breath sound, cough or sputum Using aseptic technique, SN may perform FS blood sugar every visit using patient's glucometer to assess for S/SX of hypo/hyperglycemia or accuracy of reported BS if not already done by patient. SN to report FBS >250 or <70 and RBS> 300 or <70 mg/dl to MD. Dispose sharps per OSHA guidelines. SN to assess pt's knowledge on energy conservation and home safety measures every visit, and instruct on areas of knowledge

22. Goals/Rehabilitation Potential/Discharge Plan
Goals/Rehabilitation Potential/Discharge Plans; Patient's BLOOD SUAGR level will be within Normal limits as established by MD within 60 days, Patient will have adequate working knowledge of disease process , patho, s/sx, and exacerbation OF DIABETES within 60 days. Patient will be able to list 3 out of 4 uses of DIABETIC medication within 60 days.
Patient will be able to list 2 out of 4 treatment of DIABETES. Patient will be able to state when to go to ER, or What S/SX to report to MD within 60 days.
PT Goals: Pt will demonstrate increase muscle strength, endurance, mobility and reduce pain to 1/10 by the end of Cert. period. The patient's safety will be enhanced throughout the home care service as evidenced by no falls/injuries within Cert. period of time.
Rehab potential : Good for goals stated above .

23. Nurse's Signature and Date of Verbal SOC Where Applicable
Digitally Signed by: AKANNA GERTRUDE, RN 10/21/2014

25. Date HHA Received Signed POT

24. Physician Name and Address
KETHA, SUMANA MD NPI: 1962447805
2925 SKYWAY CIRCLE Tel: 9726757313
IRVING TX 75038 Fax: 9726757310

26. I Certify/Recertify that this patient is confined to his or her home and needs intermittent nursing care, physical therapy and/or speech therapy or continuous 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 S. Ketha 12/3/14

28. Anyone who misrepresents, falsify or conceal essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) Print Aligned

HOME HEALTH CERTIFICATION AND PLAN OF CARE

ADDENDUM TO :PLAN OF TREATMENT

1. Patients HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No./NPI
450426255A	10/21/2014	From: 10/21/2014 To: 12/19/2014	OS0929	747641/1326274978

6. Patients Name and Address	7. Provider's Name, Address and Phone Number
Dorothy Adams 1407 BRAEWOOD PL DUNCANVILLE TX 75137 9723028702	Our Saviour Healthcare Services, Inc. 7205 High Point Dr Sachse TX 75048-2160 Phone: 4692351576 Fax: 4698140990

13. Other Pertinent Diagnosis

401.9 Unspecified Essential Hypertension E
716.50 Unspecified Polyarthropathy Or Polyarthritis Site e

15. Safety Measures

Plan,Keep Pathways Clear,Safety in ADLs,Standard Precuations/Infection Control,Instructed on Fall Precautions,Instructed on mobility safety/verb. unde,Instructed on sharps containers/verb. un,Instructed caregive to clear pathway,Emergency care plan,Sharp container,Fall precautions,Mobility safety,Always wear eye glasses,

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

deficit. SN to teach disease process of DIABETES, to include path physiology, S/SX, treatment and exacerbation. Assess knowledge of medication regimen and deficits, teach DIABETES medications to include action, scheduled S/E and safety measures and instruct or new on changed medications if any. SN to instruct on medication safety measures, ADA diet, importance of keeping daily BS log and other non-pharmacological management of DIABETES. Instruct on Pharmacological and Non-pharmacological pain management , skin care, incontinent care and home safety measures and all other areas of care where knowledge deficit noted. May collect Oasis data at any specific time point as required by CMS. Hold HHCS if patient transferred to inpatient facility . HHA to assist with personAl care, ADL'S and IADL'S per POC under supervision of an RN. Physical therapist to assess, evaluate and treat: Assess for gait training, mobility and ROM exercise.

22. Goals/Rehabilitation potential/Discharge Plans

HHA GOALS; Patient will achieve adequate ADL'S and IADLS' within 60 days.
D/C Plans: Patient will be discharged when goals are met and pt no longer in need of skilled nursing services or alternative POC have been arranged

23. Optional Name/Signature Of Nurse/Therapist Digitally Signed by: AKANNA GERTRUDE, RN **Date:** 10/21/2014

27. Signature Of Physician: Sloth 12/3 **Date:**

OUR SAVIOUR HEALTHCARE SERVICES INC.

7205 High Point Dr, Sachse TX 75048

Phone: (469)2351576 Fax: (469)814-0990

Confidentlal

Fax

TO: DR. SUMANA KETHA
FAX NUMBER: (972) 675-7310

FROM: Gertrude Akanna RN, DON.

BUSINESS PHONE: (469) 235-1576.
BUSINESS FAX: (469)814-0990.

Pages:___5 PAGES_____

Date/Time__10/31/2014._____

Pls leave MD sign & fax back to Our office Our fax is always busy Thanks

Subject: Communication, Post resumption of care order and 485 FOR order for Dorothy Adams

* D. Adams is not our pt.

Our Saviour Healthcare Services, Inc.
7205 High Point Dr Sachse TX 75048-2160
Phone 4692351576 Fax 4698140990

COMMUNICATION NOTE

Date:	11/11/2014	Time: 9:00 AM	
Patient's Name:	Dorothy Adams	Patient's Med. #:	OS0929
Physician Name:	KETHA SUMANA	NPI:	1962447805

To Whom it may Concern,

This note is regarding ms Dorothy Adams, Ms Adams was seen by Nurse practicioner from Dr. Ketha office on 10/24/2014. I am attaching the face to face and the Start of care admission order I received from your office. If there is any more information needed from Our Office please kindly let me. Thanks and God Bless.

Nurse Signature: Digitally Signed by: AKANNA GERTRUDE, RN **Date:** 11/11/2014

OUR SAVIOUR HEALTHCARE SERVICES INC.

7205 High Point Dr, Sachse TX 75048

Phone: (469)2351576 Fax: (469)814-0990

Confidential

Fax

TO: Dr Sumana Ketha

FAX NUMBER: (972) 675-7310

FROM: Gertrude Akanna RN, DON.

BUSINESS PHONE: (469) 235-1576.
BUSINESS FAX: (469)814-0990.

* Not a patient of Dr. Kethas. Please send referral

Pages: 5 PAGES

Date/Time 11/5/2014.

Subject: Physical therapy Evaluation for Adams Dorothy

PT Evaluation : 10/29/2014 (161799654)
Adams, Dorothy ( )
Date of Birth: 09/04/1929
☑ Patient identity confirmed

Our Saviour Healthcare Svcs Inc.
7205 High Point Dr.
SACHSE , TX 75048
4692351576

Time In: 15:30 Time Out: 16:15 Visit Date: 10/29/2014

Diagnosis / History

Medical Diagnosis: DMII, HTN

PT Diagnosis: Impaired Muscle Performance

Relevant Medical History
Pt with Jordan (CCO, went to hospital due to UTI, and was relaased and was c/o abdomen pain, and found to still have had infection but also has a hernia. PMHx: HTN, DM, Dementia,

Prior Level of Functioning
Last 5 years been in ALF. Pt did not want to use AD but needed.

Patient's Goals
Get stronger

Precautions: Cognitioin, fall risk

Homebound? ☑ Yes ☐ No

- ☑ Residual Weakness
- ☐ Needs assistance for all activities
- ☑ Requires max assistance / taxing effort to leave home
- ☑ Unable to safely leave home unattended
- ☐ Severe SOB or SOB upon exertion
- ☐ Confusion, unsafe to go out of home alone

Other:

Social Supports / Safety Hazards

Patient Living Situation and Availability of Assistance
Patient lives: In congregate situation, e.g., assisted living
Assistance is available: Around the clock

Current Types of Assistance Received

Safety / Sanitation Hazards
☑ No hazards identified

- ☐ Steps / Stairs:
- ☐ Narrow or obstructed walkway
- ☐ Cluttered / soiled living area
- ☐ No running water, plumbing
- ☐ Lack of fire safety devices
- ☐ Inadequate lighting, heating and/or cooling
- ☐ Insect / rodent infestation
- ☐ No gas / electric appliance
- ☐ Pets
- ☐ Unsecured floor coverings

Other:

Evaluation of Living Situation, Supports, and Hazards
Pt lives in single family home, ALF

Vital Signs

BP:		Position	Side	Heart Rate:	Respirations:	O2 Sat:	Room Air / Rate	Route
Prior	152 /78	Sitting	Left	Prior 97	Prior	Prior	via	
Post	/			Post	Post	Post	via	

Comments:

PT Evaluation : 10/28/2014
Adams, Dorothy ( )

Physical Assessment

Speech:	Intact	**Muscle Tone:**	abn
Vision:	intact	**Coordination:**	impaired
Hearing:	HOH	**Sensation:**	intact
Skin:	intact	**Endurance:**	fair
Edema:	none	**Posture:**	fair

Oriented: ☑ Person ☑ Place ☐ Time

Evaluation of Cognitive and/or Emotional Functioning
intact

Pain Assessment
☐ No Pain Reported

	Location	*Intensity (0-10)*		*Location*	*Intensity (0-10)*
Primary Site:	back	3	Secondary Site:		
Increased by:	movement				
Relieved by:	rest				
Interferes with:	mobility				

ROM / Strength

		ROM		Strength				ROM		Strength	
Part	*Action*	*Right*	*Left*	*Right*	*Left*	*Part*	*Action*	*Right*	*Left*	*Right*	*Left*
Shoulder	Flexion	See	Below			Hip	Flexion	WFL	WFL	4/5	4
	Extension	See	Below				Extension	WFL	WFL	4	4
	Abduction	See	Below				Abduction	WFL	WFL	4	4
	Adduction	See	Below				Adduction	WFL	WFL	4	4
	Int Rot	See	Below				Int Rot	WFL	WFL	4	4
	Ext Rot	See	Below				Ext Rot	WFL	WFL	4	4
Elbow	Flexion					Knee	Flexion	WFL	WFL	4+	4+
	Extension						Extension	WFL	WFL	4+	4+
Forearm	Pronation					Ankle	Plantar Flexion	WFL	WFL	4	4
	Supination						Dorsiflexion	WFL	WFL	4	4
Finger	Flexion						Inversion	WFL	WFL	4	4
	Extension						Eversion	WFL	WFL	4	4
Wrist	Flexion					Neck	Flexion	WFL	WFL	WFL	WFL
	Extension						Extension	WFL	WFL	WFL	WFL
Trunk	Extension	LOM	LOM	impai	impai		Lat Flexion	WFL	WFL	WFL	WFL
	Rotation	WFL	WFL	intac	intac		Rotation	WFL	WFL	WFL	WFL
	Flexion	WFL	WFL	intac	intac						

Comments:
UE grossly WFL and Strength at >3.5 bil

Functional Assessment

Independence Scale Key Dep Max Assist Mod Assist Min Assist CGA SBA Supervision Mod Indep Indep

Bed Mobility

	Assist Level	Assistive Device
Rolling	IN	☐ L ☐ R
Supine - Sit	SBA	cane
Sit - Supine	SBA	cane

Deficits Due To / Comments:

Gait

	Assist Level	Distance / Amount	Assistive Device
Level	MIN	X home	RW
Unlevel		X	
Steps / Stairs	min	X 1 step	

Deficits Due To / Deviations / Comments:
Pt this date, using cane too big with decreased step length and width.

PT Evaluation : 10/29/2014
Adams, Dorothy ( )

Transfer

	Assist Level	Assistive Device
Sit - Stand	MIN	none
Stand - Sit	MIN	none
Bed - Wheelchair		
Wheelchair - Bed		
Toilet or BSC	MIN	stick
Tub or Shower		
Car / Van		

Deficits Due To / Comments:
NONE

Wheelchair Mobility

Assist Level	Assist Level	Assist Level
Level	Unlevel	Maneuver

Deficits Due To / Comments:

Weight Bearing Status

Fall Risk and Other Testing

	Result
Test 1	
Test 2	
Test 3	

Balance

☑ Able to assume/maintain midline orientation
Sitting F
Standing F

Evaluation and Testing Description:
The Timed Up and Go test (TUG) is a simple test used to assess a person's mobility and requires both static and dynamic balance. A score of fourteen seconds or more suggests that the person may be prone to falls. The 30 second chair stand test provides a measurement of a person's lower body (particularly *(Continued)*

DME

Available
☐ Wheelchair ☑ Walker ☐ Hospital Bed ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Tub / Shower Bench
Other:
cane

Needs

Evaluation Assessment

Evaluation Assessment Summary
Pt is an 85 y/o female who presents to therapy with recent hospitalization that has impaired her gait distance and mobility. Pt would benefit from PT services to work toward improving posture and pain tolerance to increase her QOL. Pt would benefit from the pain management techniques from therapy but also the strengthening of core to improve her gait and QOL. Pt has dementia therefore pt will be hindered by her cognition. Pt would improve with skilled therapy.

Functional Limitations
☑ Decreased ROM / Strength ☑ Impaired Balance / Gait ☑ Increased Pain ☐ Decreased Wheelchair Mobility
☑ Poor Safety Awareness ☑ Decreased Transfer Ability ☐ Decreased Bed Mobility
Comments:

Treatment Goals

		Time Frame
1:	Pt will be able to perform transfers at SUP safely without risk of falling or LOB	5 weeks
2:	Pt will be ind with HEP with help from aide to promote LE and postural strength to promote normal strength in the absence of normal mobility	2 weeks
3:	Pt will be able to perform ther ex 20-25 times to help with strengthening and ROM to allow pt to be able to improve transfers and gait safety	3 weeks
4:	Pt will be able to amb community distance with AD at MI safely to be able to start outing with aide and family	5 weeks
5:	Pt will be able to report lower pain levels with gait training with use of Pain management techniques from therapy	4 weeks.
6:		
7:		
8:		
9:		
10:		

PT Evaluation : 10/29/2014
Adams, Dorothy ( )

Treatment Plan

- [x] Thera Ex
- [ ] Hip Precaution Training
- [x] Establish or Upgrade HEP
- [ ] Knee Precaution Training
- [x] Transfer Training
- [ ] Pulmonary Physical Therapy
- [x] Gait Training
- [ ] Range of Motion
- [x] Balance Training
- [x] Muscle Re-education
- [x] Bed Mobility Training
- [x] Ultrasound
- [ ] Prosthetic Training
- [x] Electrotherapy
- [ ] Stairs / Steps Training
- [ ] O2 Sat Monitoring PRN
- [x] Home Safety Training
- [x] Assistive Device Training: appropriate AD
- [x] Modalities for Pain Control: TENS unit to back prn. Ultrasound at 1Mhz for pain relief to back
- [ ] CPM:

Other:

Comments:

Care Coordination

Conference with:
[x] PT [x] PTA [ ] OT [ ] COTA [ ] ST [ ] SN [ ] Aide [ ] Supervisor Other: Therapy on Demand

Name(s): Natarsha

Regarding: POC

✓ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: [ ] OT [ ] ST [ ] MSW [ ] Aide Other:

Reason:

Statement of Rehab Potential
Fair

Treatment / Skilled Intervention This Visit
Eval and est POC with CG present. (Jordan 972 302 8702)

Frequency and Duration

	Start Date	End Date	Effective Date	Frequency
Current Episode:	10/21/2014	12/19/2014	10/29/2014	2w4 1w1
Next Episode:				

Discharge Plan
[x] To self care when goals met [x] To self care when max potential achieved [ ] To outpatient therapy with MD approval
[ ] Other:

Therapist Signature (Rhines , Chester) **& Date of Verbal Order for Start of PT Treatment**
Digitally signed by: Chester Rhines , PT
Date 10/29/2014

Physician Name
Sumana Ketha

Physician Phone: (972) 675-7313
Physician FAX: (972) 675-7310

Physician Signature S. Ketha **Date** 12/3/14

PT Evaluation Addendum Pag : 10/29/2014
Adams, Dorothy ( )

Evaluation and Testing Description

legs) strength. This is associated with the ability to perform lifestyle tasks such as climbing stairs, getting in and out of a vehicle or bath.

Adams, Dorothy ()