Department of Health and Human Services
CMS

Form Approved
OBM 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. / NPI
465336765A	05/09/2016	From: 07/08/2016 To: 09/05/2016	EMH359	743125 / 1417064619

6. Patient's Name and Address
Brown Jackeline D
11760 Ferguson Rd Apt #1003, building A
Dallas, TX 75228 **Tel:** 214-916-8861

7. Provider's Name, Address and Telephone Number
EMRICK SERVICES INC
2301 Forest Lane, Suite 400 **Fax:** 972-494-2331
Garland, TX 75042 **Tel:** 972-494-5444

8. Date of Birth: 10/05/1966

9. Sex: ☐ M ☑ F

11. ICD	Principal Diagnosis	Date
J45.909	Unspecified asthma, uncomplicated	

12. ICD	Surgical Procedure	Date

13. ICD	Other Pertinent Diagnosis	Date
M15.9	Polyosteoarthritis, unspecified	
I11.9	Hypertensive heart disease without heart failure	
R26.89	Other abnormalities of gait and mobility	
K21.9	Gastro-esophageal reflux disease without esophagitis	
M10.9	Gout, unspecified	
G60.8	Other hereditary and idiopathic neuropathies	
K74.60	Unspecified cirrhosis of liver	

10. Medication: Dose/Frequency/Route (N)ew (C)hanged
ASPIRIN 325 MG 1 TAB QD PO
ACETAMINOPHEN WITH HYDROCODONE 325/10 MG 1 TAB Q 4HRS PRN PO
METOPROLOL TARTRATE 25 MG 1 TAB BID PO
PANTOPRAZOLE SODIUM 40 MG 1 TAB QD PO
ALBUTEROL HFA INH 90 MCG 2 PUFFS Q 4HRS PRN SOB PO
LACTOBACILLUS ACIDOPHILUS CHEWABLE TABS I TAB TID PO
FLUTICASONE/SALMETEROL 250MCG/50MCG INH POWDER 1 PUFF Q 12 HRS PO
GABAPENTIN 100 MG 1 CAP TID PO

14. DME and Supplies: gloves, ALCOHOL PADS, PROBE COVERS

15. Safety Measures: Falls,Anticoagulation,Infection Control/Standard precautions,

16. Nutritional Req: Diabetic, heart healthy diet

17. Allergies: NKDA

18. A. Functional Limitations

1 ☐	Amputation	5 ☐	Paralysis	9 ☐	Legally Blind
2 ☑	Bowel/Bladder(Incontinence)	6 ☑	Endurance	A ☑	Dyspnea w/Min.Exertion
3 ☐	Contracture	7 ☑	Ambulation	B ☐	Other:(specify)
4 ☑	Hearing	8 ☐	Speech		

18. B. Activities Permitted

1 ☐	Complete Bedrest	6 ☐	Partial Weight Bearing	A ☐	Wheelchair
2 ☐	Bedrest BRP	7 ☐	Independant At Home	B ☑	Walker
3 ☑	Up As Tolerated	8 ☐	Crutches	C ☐	No Restriction
4 ☐	Transfer Bed/Chair	9 ☑	Cane	D ☐	Other:(specify)
5 ☐	Exercises Prescribed				

19. Mental Status
1 ☑ Oriented 3 ☑ Forgetful 5 ☐ Disoriented 7 ☐ Agitated
2 ☐ Comatose 4 ☐ Depressed 6 ☐ Lethargic 8 ☐ Other:

20. Prognosis
1 ☐ Poor 2 ☐ Guarded 3 ☑ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
SN Frequency: 1w9 beginning week of 07/17/16
PRN visit 2 for problems related to Asthma, Polyarthritis, unstable vs, and falls.
SN/PT/OT TO ASSESS:All systems, with emphasis on Neuro/Sensory Respiratory Pain GI/Digestive Urinary Endocrine Musculoskeletal Cardiovascular Intergumentary
Assess: V/S's and report abnormal or pertinent findings: Temp <95 or >100.0, Pulse <50 or 110/min, Resp <12 or >28/min, systolic BP <90mmHG or 180mmHG and/or diastolic BP, 50 or >100mmHG.
SN to instruct patient / caregiver on regarding disease process of Asthma including signs and symptoms to report, management, diet/ medication regimen, risk factors, precaution, possible complications.
SN to assess patient's response to new/changed medications, instruct pt/cg in new/changed medication regime, including schedule, purpose, and possible side effects or adverse reactions
SN to assess/instruct pt/cg in all aspects of disease processes of Polyarthritis, s/sx of exacerbation home management of disease process Polyarthritis and when to notify nurse or physician.

22. Goals/Rehabilitation Potential/Discharge Plans
SN GOALS: Pt/cg will verbalize knowledge of disease process Asthma and Polyarthritis, s/sx of exacerbations and when to notify MD by EOE.
BP range will be WNL by EOE.
Pt will be knowledgeable of: new/changed medication regimen s/sx of exacerbation and when to notify physician/SN.
Pt's pain will be managed at <3 on the scale of 1-10 within 60 days.
Pt will have Fall Risk assessment using TUG testing with result of <14 sec at the end of episode.
Pulmonary status will improve as evidenced by adequate oxygenation, less dyspnea, improved activity tolerance, and ability to perform ADL's without exhaustion by EOE.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Thomas-Stahle Nancy Ann, RN 07/06/2016

25. Date HHA Received Signed POC 09/20/2016

24. Physician's Name and Address
KETHA, SUMANA ,MD
2925 Skyway Cir N Ste. B
Irving, TX 75038
NPI 1962447805
Fax: 972-675-7310
Tel: 972-675-7313

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.
I estimate continued services will be required for _____
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 & Date Signed 09/20/2016
S.Ketha M.D

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** ☑ **Medical Update**

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8. Item No.

485 Cont/d 10. Medication: Dose/Frequency/Route (N)ew (C)hanged

485 Cont/d 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
NEUROLOGICAL ORDERS: SN to assess/instruct pt/cg on knowledge deficits in s/sx or management of Neuropathy..
RESPIRATORY ORDERS: SN may check O2 sats per pulse oximetry PRN for assessment or signs of Resp difficulty, notify physician if O2 sats < 90%.
SN to assess/instruct pt/cg on effectiveness of aerosol inhalers and nebulizer.
SN to assess/instruct pt/cg s/sx of complications or infections.
MUSCULOSKELETAL ORDERS: SN to assess/instruct pt/cg on interventions in pain management, including pharmacological and comfort measures.
SN will notify physician of pain level above 5 on a scale of 0-10.
SN to assess home for safety, assess for risk for fall every visit using TUG testing. (check only if TUG result is > 14 sec)
Hold Home Health Services if patient transfers to inpatient facility. May resume Home Health Services upon discharge from in patient facility before 61st day of episode.
SN to assess/instruct pt/cg in emergency preparedness.
SN may accept orders from other consulting physicians.

485 Cont/d 22. Goals/Rehabilitation Potential/Discharge Plans
REHAB POTENTIAL: FAIR to accomplish goals.
DISCHARGE PLANS: DISCHARGE pt under supervision of physician when goals are met and skilled services are no longer required.
DISCHARGE SUMMARY: WILL be available upon MD's request.

Other Comments

9. Signature of Physician S.Kotha M.D **10. Date** 09/20/2016

11. Optional Name/Signature of Nurse/Therapist **12. Date**

MEDICAL UPDATE AND PATIENT INFORMATION

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8. Medicare Covered: ☑ Y ☐ N

9. Date Physician Last Saw Patient:

10. Date Last Contacted Physician:

11. Is Patient Recieving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent?: ☐ Y ☑ N ☐ Do Not Know

12. ☐ Certification ☑ Re-Certification ☐ Modified

13. Dates of Last InPatient Stay: Admission: **05/23/2016** Discharge: **05/26/2016**

14. Type of Facility: **Hospital**

15. Updated Information : New Orders/Treatment/Clinical Facts/Summary from Each Discipline:

16. Functional Limitations (Expand Form 485 and Level of ADL) Reason Homebound/Prior Functional Status
Criteria 1A: Patient ambulates with a cane or walker due to pain in joints related to Polyosteoarthrosis. Criteria 2A atient has SOB due to Asthma, and pain related to Osteoarthrosis, which makes it difficult for her to walk. Criteria 2B:Patient unable to leave home often because of pain related to Osteoarthrosis. Criteria 2C:Patient leaves home for doctors' appointments.

17. Supplementary Plan of Care from Physician Other than Referring Physician : (If Yes, Please Specify Giving Goals / Rehab.Potential / Discharge Plan) ☐ Y ☑ N

18. Unusual Home / Social Environment

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

20. Specify Any Known medical and/or Non Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurence

21. Nurse or Therapist Completing or Reviewing Form
Thomas-Stahle Nancy Ann, RN

22. Date (Mo., Day, Yr.)
07/06/2016