

**INTEGRIS**
HOME HEALTH CARE

Integrus • Excellence • Commitment

INTEGRIS HOME HEALTH CARE, LLC

2735 VILLA CREEK DRIVE • SUITE 142 • DALLAS, TEXAS 75234

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FROM: Shell TO: Dr Ketha
CONTACT NUMBER: _____ CONTACT NUMBER: _____
ORGANIZATION: _____ ORGANIZATION: _____
FAX NUMBER: _____ FAX NUMBER: 972 675 7310
PAGES: (3)

NOTES:

Please Sign &
fax back

Thank you!

FAXED
11/18/14**FAXED**
10/29/14


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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: 10/23/2014 To: 12/21/2014	
				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@integrishhc.com		
8. Date of Birth 10/19/1983			9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		
11. ICD-9-CM Principal Diagnosis 333.99 Extrapyramidal dis NEC		Date 10/23/2014		10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged HALOPERIDOL 10 MG ORAL TABLET 1 tab QID By mouth (PO) U DEPAKOTE 500 MG ORAL DELAYED RELEASE TABLET 1 tab morning 2 tabs night By mouth (PO) U DIPHENHYDRAMINE 50 MG ORAL CAPSULE 1 tab twice daily By mouth (PO) U TRAZODONE 100 MG ORAL TABLET 1 tab at bedtime pm By mouth (PO) U LORAZEPAM 2 MG ORAL TABLET 1 tab every 6 hours By mouth (PO) N	
12. ICD-9-CM Surgical Procedure		Date			
13. ICD-9-CM Other Pertinent Diagnoses 724.3 Sciatica 401.9 Hypertension NOS V58.69 Long-term use meds NEC 300.00 Anxiety state NOS		Date 10/23/2014 10/23/2014 10/23/2014 10/23/2014			
14. DME and Supplies , Alcohol Pads, Exam Gloves, Probe Covers, Tape, blood pressure			15. Safety Measures: Emergency Plan Developed, Safety in ADLs, Slow Position Change,		
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 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, concentration			4 <input type="checkbox"/> Transfer Bed/Chair 9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify)		
19. Mental Status:			5 <input type="checkbox"/> Exerases Prescribed		
1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated			6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other		
2 <input type="checkbox"/> Comatose 4 <input checked="" type="checkbox"/> Depressed			3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent		
20. Prognosis:			1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded		
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN Frequency: 1W9. PT Frequency: evaluate and treat. OT Frequency: evaluate and treat. MSW Frequency: evaluate for community resources. 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 determine (and educate) if the patient/caregiver is able to identify the correct dose, route, desired effect, precautions, and frequency of each medication. MSW to assess psychosocial needs, environment and assist with community referrals and resources. SN to develop individualized emergency plan with patient. SN to assess pain level and effectiveness of nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, and to report to physician if patient experiences pain level not acceptable to patient level not acceptable to patient, or pain level greater 5/10. SN to assess for burning pain, sensitivity to touch, lack of coordination, and numbness or tingling in feet, hands, legs, and arms. 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 and assess patient/caregiver for diet compliance. SN to notify physician this patient was screened for depression using the PHQ-2 scale and meets criteria for further evaluation for depression. MSW: visits, every 60 days for provider services. SN to assess/instruct on pain					
22. Goals/Rehabilitation Potential/Discharge Plans 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 12/22/2014. The patient will have no hospitalizations during the episode. 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.					
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Monica Todd RN 10/23/2014				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			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

Form 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: 10/23/2014 To: 12/21/2014	4. Medical Record No. IHHC-127	5. Provider No. 747682
6. Patient's Name: Alsip, Jeromy		7. Provider's Name Integris Home Health Care, LLC		
10. Medications INVEGA SUSTENNA 234 MG/1.5 ML INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE prn Intramuscular (IM) U				
13. Diagnoses 296.82 / Atypical depressive dis / 10/23/2014				
14. DME and Supplies monitor				
15. Safety Measures Standard Precautions/Infection Control, Instructed on disaster/emergency plan				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) management, proper body mechanics and safety measures. 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 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. Physical therapist to evaluate and submit plan of treatment.				
22. Goals/Rehabilitation Potential/Discharge Plans Patient/Caregiver will demonstrate/verbalize knowledge regarding daily skin and foot exams (areas affected by neuropathy) by the end of the episode. The Patient/Caregiver will verbalize understanding of symptoms of cardiac complications and when to call 911 by 12/15/2014. Patient will maintain 75% diet compliance and verbalize knowledge and examples of the heart healthy nutritional plan. Patient will have optimal cognitive functioning within parameters established for the stage of disease by the end of the episode. 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. eye and dental Rehab Potential: Fair for stated goals.				
9. Signature of Physician: 			10. Date:	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN			12. Date 10/23/2014	