

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 2458-8745	2. Start Of Care Date 4/17/2004	3. Certification Period From 4/17/2004 To: 6/16/2004	4. Medical Record No. 1111	5. Provider No. 22222
--	------------------------------------	---	-------------------------------	--------------------------

6. Patient's Name and Address: Dorothy Adams 500 University Ave. Mount Pleasant MI 48858	7. Provider's Name, Address and Telephone Harbor Home Health Care (989) 773-3333 3377 Enterprise Dr. Mt. Pleasant, MI 48858
---	--

8. Date of Birth 1/20/1921	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged
11. ICD-9-CM 4280	Principle Diagnosis CONGESTIVE HEART FAILURE	Date 2/20/2004
12. ICD-9-CM 374	Surgical Procedure HEART & PERICARD REPAIR	Date 1/1/2004
13. ICD-9-CM: 8413	Other Pertinent Diagnosis SPRAIN ULNOHUMERAL	Date
14. DME and Supplies Walker, cane.		15. Safety Measures: Guard rails in bathroom. Phone near client's chair and bed.
16. Nutritional Req. normal diet		17. Allergies: none known
18.A. Functional Limitati		18.B. Activities Permit
1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea 3 <input type="checkbox"/> Contracture 7 <input type="checkbox"/> Ambulation B <input type="checkbox"/> Other Limitation 4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech		1 <input type="checkbox"/> Complete Bedrest 6 <input checked="" type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 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 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 type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input checked="" type="checkbox"/> Excellent		

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

22. Goals/Rehabilitation Potential/Discharge Plans
Patient should make a full recovery. Begin PT in approximately 6 weeks.

23. Nurse's Signature and Date of Verbal SOC Where Applicable	25. Date HHA Received Signed 2/23/2004
---	---

24. Physician's Name and Address Dr. Phil Storey	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.
---	--

