Department of Health and Human Services
Centers for Medicare & Medicaid Services

Actions >

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.
000491675	07/02/2009	From: 07/02/2009 To: 09/02/2009	541234	0123456789

6. Patient's Name and Address

Chris Bale
11 Second Street
Hometown, PA 10981

7. Provider's Name, Address and Telephone Number

Very Good Home Care
Health Rd.
Hometwon, PA 10981

8. Date of Birth **07/16/1926**

9. Sex [X] M [ ] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Drug	Dose	Frequency	Route	N/C
Humulin N	24 units	every am	SubQ	C
Tylenol	325 mg	q 4h prn pain	P.O.	N
Mom	30 ml	at bedtime prn	P.O.	

11. ICD-9-CM	Principal Diagnosis	Date
891.0	Open Wound Foot	07/01/09

12. ICD-9-CM	Surgical Procedure	Date
86.28	Debridement Wound	07/01/09

13. ICD-9-CM	Other Pertinent Diagnoses	Date
250.03	Type 2 Diabetes Mellitus uncontrolled	04/01/09
250.07	Diabetes with peripheral circulatory disorders	04/01/09
290.1	Presenile Dementia	04/01/09
443.89	Peripheral Vascular Disease	04/01/09
300.2	Phobic Disorders	04/01/09

14. DME and Supplies
Walker; Wound Care; Supplies

15. Safety Measures:
Correct use of supportive devices

16. Nutritional Req. **20% protein 30% fat**

17. Allergies: **NKA**

18.A. Functional Limitations

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

18.B. Activities Permitted

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

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

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

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

SN: Observe/assess: Cardiopulmonary, respiratory, musculoskeletal, gastrointestinal, and circulatory systems function. Assess: nutritional intake and dietary compliance related to wound healing; skin integrity and peripheral pulses; diabetic home management; and home safety. Instruct pt./caregiver in: diabetic management; signs/symptoms of wound infection; wound care; home safety and emergency measures. SN to provide: wound care until pt. is independent: daily wound care to left ankle area = clean area with saline and apply wet to dry saline dressing. SN visits: 5-7/wk X 3 wks; 1-3/wk X 3wks.

22. Goals/Rehabilitation Potential/Discharge Plans

SN: GOALS: Wound healing without infection or further complications, compliance with diabetic home management. Rehab potential to achieve goals: fair. Discharge plan: to family/self when care is independent.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
07/02/09

25. Date HHA Received Signed POT
07/12/09

24. Physician's Name and Address

Dr. Marcus Welby
Hills Medical Center
Hometown, PA 10981

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
07/07/09

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

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 and Address:	7. Providers Name
Chris Bale	**Very Good Home Care**

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9. Signature of Physician:	10. Date: **7/6/2009**
11. Optional Name / Signature of Nurse / Therapist	12. Date **7/6/2009**