

Home Health Certification and Plan of Care						Order ID: 1183/257			
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
5A97T15GD69		08/11/2025		From: 08/11/2025 To: 10/09/2025		FaxTest01		067117	
6. Patient's Name and Address Fax Test 12 Boston St., BALTIMORE, MD 21213 999-999-9999					7. Provider's Name, Address and Telephone Number Delta Health Home Health 70 Stafford Land Suite C Delta, CO 81416-2282 970-874-2463 1356449631				
8. DOB 09/03/1960 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Metformin - Metformin Hydrochloride 500 mg by mouth once a day Simvastatin - Simvastatin 20 mg 1 Tablet by mouth in the evening				
11. ICD 110.		Principal Diagnosis Essential (primary) hypertension			Date 08/11/25				
13. ICD E11.9		Other Pertinent Diagnoses Type 2 diabetes mellitus without complications			Date 08/11/25				
14. DME and Supplies: walker					15. Safety Measures: walker precautions				
16. Nutrition: diabetic					17. Allergies: no known allergies				
18.A. Functional Limitations None of the above					18.B. Activities Permitted Walker				
19. Mental & Psychosocial Status:					COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, HISTORY OF DEPRESSION: No				
20. Prognosis:					fair				
22. A Rehabilitation Potential: SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.					22.B.Discharge Plans family/caregiver will be responsible for managing treatment				
Homebound status:					patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home				
Clinical Condition Requiring Homecare:					Diabetes, Hypertension				
SN Careplans					SN Goals				
SN WK1: 1 (08/11/25-08/16/25) ,WK2: 1 (08/17/25-08/23/25) ,WK3: 1 (08/24/25-08/30/25) ,WK4: 1 (08/31/25-09/06/25) ,WK5: 1 (09/07/25-09/13/25)					PATIENT-STATED GOAL: I want to walk without a walker				
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 96 > 100, heart rate < 50 > 120, respiratory rate < 12 > 24, blood pressure systolic < 100 > 160, blood pressure diastolic < 50 > 100, O2 saturation < 88 > 100, pain < 0 > 5, blood sugar < 60 > 300					GOALS patient/caregiver recalls * how to take the patient's blood pressure * record the reading * recalls related medication(s) purpose, schedule				
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance					patient/caregiver recalls * diabetic medication management * blood sugar testing * diabetic foot care * exercise * diabetic diet * recalls related medication(s) purpose, schedule				
HOSPITALIZATION RISKS: 10. None of the above					patient/caregiver recalls * lifestyle modifications to manage respiratory condition including * diet changes and regular exercise * strategies to control shortness of breath * home remedies to keep lungs healthy * recalls related medication(s) purpose, schedule				
STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits Advance Directive:No Advance Directive					patient/caregiver recalls * management of mental health condition including joining a peer group * maintaining regular contact with mental health professional * avoiding known stressors * controlling impulses * recalls related medication(s) purpose, schedule				
PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, chest pain, lightheadedness, abnormal BS < 70/140 > mg/dL, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit					patient/caregiver recalls * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lightinn				
PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities									
TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule									
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Team MHCB, on 08/11/2025						25. Date HHA Received Signed POT			
24. Physician's Name and Address Physician Test 310, NATARAJAPURAM 4TH EAST STREET KVP, HI 628502 PHONE: 999-999-999 FAX: 12072219995 NPI: 1801093936					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. F2F date : 08/09/2025				
27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face					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. PAGE 1 of 2				

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		* using mechanical aids patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Team MHCB,	08/11/2025