Home Health Certification and Plan of Care

Order ID: 1150/13739

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01199471	11/04/2025	From: 11/04/2025 To: 01/02/2026	18440	217058

6. Patient's Name and Address

Donna Beal
1015 5th St,
GLEN BURNIE, MD 21060-
443-474-4286

7. Provider's Name, Address and Telephone Number

HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 11/26/1953 | 9.Sex Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	11/04/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	11/04/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	11/04/25
N18.31	Chronic kidney disease stage 3a	11/04/25
F41.9	Anxiety disorder unspecified	11/04/25
C34.91	Malignant neoplasm of unsp part of right bronchus or lung	11/04/25
C79.51	Secondary malignant neoplasm of bone	11/04/25
J45.909	Unspecified asthma uncomplicated	11/04/25
M85.80	Oth disrd of bone density and structure unspecified site	11/04/25
F33.42	Major depressive disorder recurrent in full remission	11/04/25
R73.03	Prediabetes	11/04/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	11/04/25
E55.9	Vitamin D deficiency unspecified	11/04/25
R91.8	Other nonspecific abnormal finding of lung field	11/04/25
E66.9	Obesity unspecified	11/04/25
Z68.36	Body mass index [BMI] 36.0-36.9 adult	11/04/25
Z79.82	Long term (current) use of aspirin	11/04/25
Z96.642	Presence of left artificial hip joint	11/04/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	11/04/25
Z87.891	Personal history of nicotine dependence	11/04/25

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

Colace - Docusate Sodium 100 mg, Take 1 capsule by mouth twice a day
Roxicodone - Oxycodone Hydrochloride 5 mg, Take 1 tablet by mouth every 4 hours Take 1 tablet by mouth every 4 hours as needed for pain (1-2 tabs as needed)
Vitamin B - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Tablet by mouth as necessary
Effexor Xr - Venlafaxine Hydrochloride 150 mg , Take 1 capsule by mouth in the morning Take 1 capsule by mouth every morning for mood
Lipitor - Atorvastatin Calcium 80 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for stroke and heart protection
Dulcolax - Bisacodyl 5 mg, Take 2 tablets by mouth once a day Take 2 tablets by mouth one time with at least 8 ounces of water at 12 noon the day before procedure
Maalox - Simethicone 80 mg, Chew and swallow 2 tablets by mouth as necessary Chew and swallow 2 tablets by mouth for 3 doses, at 9 PM and 10 PM the night before procedure, and the morning of the procedure, before drinking the final one third of the Gavilyte (Patient not taking: Reported on 10/8/2025)
Zyrtec - Cetirizine Hydrochloride 10 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for 7 days
Tenormin - Atenolol 50 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for hypertension and history

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/04/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
James Huang
8028 Ritchie Hwy
Pasadena, MD 21122
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709

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 : 10/08/2025

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.

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of stroke
instead of
metoprolol
XL
Phentermine Hydrochloride - Phentermine Hydrochloride 15 mg, Take one capsule by mouth as necessary Take one
capsule
every other
morning
alternating
with 2
capsules
every other
morning for
weight loss
(Patient not
taking:
Reported on
10/8/2025)
Protonix - Pantoprazole Sodium 40 mg, Take 1 tablet by mouth in the morning Take 1 tablet
by mouth
daily before
breakfast for
acid blocker
instead of
famotidine
Proair - Proair 90 mcg/actuation, Inhale 1 puff inhalant every 6 hours
Ascorbic Acid - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 500 mg, Takes OTC daily (Tablet) by mouth once a day
Aspirin - Aspirin 81 mg, Tablet by mouth once a day One a day
with food for
hx stroke
Cyanocobalamin - Cyanocobalamin 5,000 mcg, Tablet by mouth once a day Takes daily
OTC
(Patient not
taking:
Reported on
10/8/2025)
turmeric 450 MG, Takes turmeric with ginger OTC by mouth as necessary
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit), Take 1 capsule by mouth once a day
Calcium Carbonate, Famotidine And Magnesium Hydroxide - Calcium Carbonate: Famotidine: Magnesium Hydroxide (OYST-CAL 500) 500 mg calcium (1,250 mg), Take 1 tablet by mouth twice a day Take 1 tablet
by mouth 2
times a day
with meals
Cetirizine Hydrochloride - Cetirizine Hydrochloride 10 mg, Tablet by mouth once a day one a day as
needed for
allergies
Oxaydo - Oxycodone Hydrochloride 5mg by mouth every 4 hours Severe pain
Extra Strength Tylenol - Acetaminophen 1000 by mouth every 6 hours Pain

14. DME and Supplies:	15. Safety Measures:
walker, , cane, bath bench	walker precautions, , knee precautions, , aspiration precautions, , ambulates with device
16. Nutrition:	**17. Allergies:**
Z. NO PHYSICIAN-ORDERED DIET	adhesive tape chlorhexidein gluconate codeine nickel nsaids percocet
18.A. Functional Limitations	**18.B. Activities Permitted**
Dyspnea With Minimal Exertion, Ambulation, Endurance	Cane, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

22. A Rehabilitation Potential:	22.B.Discharge Plans

Signature of Physician:	Date
	PAGE 2 of 5
Optional Name/Signature of Nurse/Therapist:	**Date**
Electronically Signed by Messick, Charles RN	11/04/2025

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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.

patient will be responsible for managing treatment

Homebound status: After undergoing Right Total Knee Replacement, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:

The patient is a 71-year-old female with a past medical history significant for hyperlipidemia, hypertension, stroke, and depression. She underwent a right total knee replacement (TKR) on November 3, 2025, and was discharged home the same day under the care of her husband and daughter. The patient is alert and oriented 4 and denies chest pain, palpitations, or dizziness. Lung sounds are clear bilaterally, bowel sounds are normoactive with last bowel movement noted yesterday, and urination is without difficulty. No peripheral edema is present, and pedal pulses are palpable. During the physical therapy evaluation, the patient demonstrated decreased endurance, right lower extremity weakness, and reduced functional mobility, all contributing to an increased risk for falls. She requires assistance from another person and an assistive device to safely ambulate outside the home. Specific impairments noted include right knee pain, limited range of motion, difficulty negotiating steps, unsteady gait, decreased balance, and decreased safety awareness. The patient requires minimal assistance to stand, transfer, and perform bed mobility tasks, and supervision to ambulate with a walker. Skilled physical therapy is medically necessary to improve strength, balance, gait mechanics, transfer safety, and overall mobility, thereby reducing fall risk and promoting a return to prior level of function. The patient and her caregiver received comprehensive education on several key topics. Infection prevention was reviewed in detail, including signs and symptoms of wound or incision infection such as fever, redness, swelling, discharge, or worsening pain. The patient was instructed to report these findings to her provider immediately. Education was also provided on edema management, emphasizing limb elevation above heart level during rest and the possible use of compression garments if recommended by her physician. Home safety instruction was reinforced, including fall prevention strategies, environmental modifications, and proper use of assistive devices. The patient was taught safe transfer techniques with a walker, correct hand and foot placement, forward weight shifting, and reaching back before sitting to prevent falls. Bed mobility techniques were demonstrated with cues for proper body mechanics to enhance independence. The patient was instructed and participated in a home exercise program (HEP) consisting of supine therapeutic exercises, including ankle pumps, quad sets, and gluteal sets (1 set 20 reps each), and heel slides (1 set 10 reps). A written copy of the HEP was provided with instructions to perform twice daily. The patient was also educated on a progressive ambulation program, beginning with short walks every 1-2 hours within the home and gradually increasing distance and duration as tolerated. Ice therapy for the right knee was recommended for 20 minutes per session with a protective barrier and skin checks every five minutes. Pain is currently well controlled with prescribed medications. The patient was counseled on optimal pain management strategies, including taking pain medication at the onset of pain and approximately one hour prior to physical therapy sessions. Side effects such as dizziness and constipation were discussed, and the patient was instructed to notify her healthcare provider or seek emergency care for chest pain, unrelieved pain, or shortness of breath. The plan of care includes skilled home physical therapy at a frequency of 3 times per week for two weeks (Tu/Wed/Thu, then Mon/Tue/Thu), with continued focus on strengthening, gait training, safety education, and progressive mobility. The patient will follow up with Dr. Hans on November 17, 2025, and is scheduled to transition to outpatient physical therapy beginning November 18, 2025. Both the patient and her caregiver verbalized understanding and agreement with the current plan of care.
 Date of Order 11/04/2025 Orders Physician Face-to-Face Date: 10/08/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Knee Replacement Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: eval Physician Huang , James

SN Careplans

SN WK1: 1 (11/04/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

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; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SpO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.

SN Goals

PATIENT-STATED GOAL: I want to walk without pain

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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

patient/caregiver recalls
* diet
* weight-bearing exercises to promote bone healing and strengthening
* fluids to prevent constipation

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/04/2025

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Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, heartburn/indigestion, constipation, swelling of affected area, muscle weakness, limited strength, limited endurance, limited range of motion, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, obesity, swell/redness surround. skin, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, physician-ordered wound care: To right knee surgical site- Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed., teach/coordinate/arrange medication packaging and/or administration

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, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * dietary guidelines for managing nutritional deficit, related medication(s) purpose, schedule, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, 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, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* home safety
* pain control
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary guidelines for managing nutritional deficit
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* 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
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 3 (11/04/25-11/08/25) ,WK2: 3 (11/09/25-11/15/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities, gait training on uneven surfaces, gait training/stair training, transfers training, assist with infection control, assist with fall prevention

TEACH PATIENT/CAREGIVER: * 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or

PT Goals

PATIENT-STATED GOAL: I want to be able to walk without any pain

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

Toilet Transfer - 06. Independent

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

patient/caregiver recalls
* 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
* recalls related medication(s) purpose, schedule

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/04/2025

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touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Car Transfer - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 5 of 5
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