Home Health Certification and Plan of Care

Order ID: 1150/17903

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47201820800	04/11/2026	From: 04/11/2026 To: 06/09/2026	24689	217058

6. Patient's Name and Address

Robin Granofsky
3501 KINGSLEY COURT APT A,
PASADENA, MD 21122-
410-507-8847

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 05/14/1958 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J18.9	Pneumonia unspecified organism	04/11/26

13. ICD	Other Pertinent Diagnoses	Date
M21.371	Foot drop right foot	04/11/26
G62.9	Polyneuropathy unspecified	04/11/26
M79.606	Pain in leg unspecified	04/11/26
M79.629	Pain in unspecified upper arm	04/11/26
G89.29	Other chronic pain	04/11/26
E78.5	Hyperlipidemia unspecified	04/11/26
G25.81	Restless legs syndrome	04/11/26
F41.9	Anxiety disorder unspecified	04/11/26
F32.A	Depression unspecified	04/11/26
G43.909	Migraine unsp not intractable without status migrainosus	04/11/26
G47.00	Insomnia unspecified	04/11/26
F17.210	Nicotine dependence cigarettes uncomplicated	04/11/26
Z79.891	Long term (current) use of opiate analgesic	04/11/26

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

ATORVASTATIN 20 MG by mouth daily Commonly known as: LIPITOR
FAMOTIDINE 40 MG by mouth daily Commonly known as: PEPCID
MEMANTINE HYDROCHLORIDE 10 MG by mouth 2 times daily Commonly known as: NAMENDA
SUMATRIPTAN 100 MG by mouth once as needed for Migraine (do not exceed in 24 hours) Commonly known as: IMITREX
ZOLPIDEM 5 MG by mouth nightly as needed for Sleep Commonly known as: AMBIEN
NICOTINE 14 MG/24HR patch / Place 1 patch onto the skin once a day Commonly known as: NICODERM CQ
Doxepin Hydrochloride - Doxepin Hydrochloride 25 mg/capsule / Take 75 mg by mouth nightly Commonly known as: SINEquan
FLUOXETINE 20 mg/tablet / Take 60 mg by mouth daily 3 capsules daily. Commonly known as: PROzac
ROPINIROLE HYDROCHLORIDE 0.25 mg/tablet / Take 0.5 mg by mouth in the evening Increase to 2 tablets after 1 week if tolerated. Commonly known as: REQUIP
Therapeutic-M Tabs 1 tablet by mouth daily

14. DME and Supplies:

None of the above

15. Safety Measures:

standard precautions, fall precautions, precautions, ambulates with assistance

16. Nutrition:

cardiac diet

17. Allergies:

sulfa

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated

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

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Pneumonia unspecified organism, 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 67-year-old female admitted to skilled home health services for medication management and disease process education related to hypoxic respiratory failure, anxiety, and chronic joint pain. Admission paperwork was completed, and consent for services was signed by the patient. The patient agreed to the established plan of care, with skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> scheduled at a frequency of 1 visit for the first week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> over the next two weeks, and then 1 visit weekly for five additional weeks. The patient's past medical history is significant for anxiety and depression, migraine headaches managed with sumatriptan (Imitrex) and Botox injections every three months, nicotine dependence, chronic hypoxic respiratory failure with dyspnea on exertion, chronic pain, right foot drop with associated neuropathy, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-hypertension">hypertension</mh>, prior inflammatory lung infection, and status post left thyroidectomy. The patient also reports a history of pneumonia approximately six months ago and an allergy to sulfa medications. At the time of assessment, the patient was alert and oriented, cooperative, and able to participate in the visit. She reports being in good spirits, stating that her anxiety and depression are currently well managed with her prescribed medication regimen. The patient denies any suicidal ideation or thoughts of self-harm. Medication reconciliation was performed with no missing medications or refill needs identified. Pain is reported as well controlled with the current medication regimen. Education was provided regarding medication adherence, potential side effects, and when to report concerns to the healthcare provider. Additional teaching was provided regarding effective pain management strategies, including taking pain medication at the onset of pain and monitoring for potential side effects such as dizziness or constipation. The patient reports a history of smoking but is currently using nicotine patches and denies current urges to smoke. She is currently using supplemental oxygen at 3 liters per minute, which was initiated approximately one week prior to the visit. The patient reports ongoing shortness of breath with exertion and heavy breathing with activity. She is scheduled to follow up with a pulmonologist for further evaluation of her respiratory condition. The patient also reports chronic joint pain affecting multiple areas, including the right shoulder and knee, which previously responded to injections but has recently become more persistent. Migraine headaches occur intermittently but have improved with Botox injections. Functionally, the patient reports independence with activities of daily living with supervision as needed. She works as a receptionist and reports that her job requires walking and answering phone calls; she expressed a desire to return to work as soon as her condition allows. The patient lives with her spouse in an apartment that requires navigating eight steps indoors and an additional three steps outside for entry and exit. She reports a history of four falls within the past year, primarily related to difficulty clearing her right foot due to foot drop. The patient ambulates within the home without an assistive device but frequently uses furniture for support. She owns a cane but reports infrequent use, although she acknowledges that using a cane would likely improve her mobility and safety. The home environment was noted to be somewhat cluttered, contributing to increased fall risk. The patient also reports symptoms of neuropathy including decreased sensation in the plantar surface of the right foot and left heel, intermittent "pins and needles" sensations in the feet, generalized fatigue, and easy bruising. She also reports a history of right eye cataract surgery with lens placement. Physical therapy evaluation identified deficits including generalized osteoarthritis-related pain, decreased bilateral lower extremity strength, impaired balance, decreased functional mobility, difficulty negotiating stairs, shortness of breath with activity, decreased safety awareness, and an overall increased risk for falls. The patient required standby assistance for safe transfers and ambulation during the visit. She was instructed in safe transfer techniques including proper hand and foot placement, forward weight shift, and reaching back for the chair prior to sitting. The patient participated in seated therapeutic exercises

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Kenneth Villar
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1235314436

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 : 04/07/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/17903

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47201820800	04/11/2026	From: 04/11/2026 To: 06/09/2026	24689	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Robin Granofsky 3501 KINGSLEY COURT APT A, PASADENA, MD 21122- 410-507-8847	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

including hip flexion, long arc quadriceps, hip abduction, and pillow squeezes for one set of 10-15 repetitions. A home exercise program was provided with instructions to perform exercises twice daily. The patient was also instructed in safe ambulation techniques on level surfaces and provided cues to improve step height and length for safety. Gait assessments, including Tinetti and Timed Up and Go (TUG), were completed, and the patient was strongly encouraged to utilize a cane consistently to reduce fall risk. Additional education was provided on fall prevention strategies, home safety modifications, and risk factors for falls based on patient handbook guidelines. The patient was also instructed on the importance of daily ambulation to promote circulation and prevent complications associated with inactivity. She was advised to initiate a walking program consisting of short walks within the home every one to two hours, beginning with 3-5 minutes and gradually increasing duration as tolerated. The patient was also instructed to visually inspect her feet regularly due to reduced sensation associated with neuropathy. The patient meets homebound criteria due to cardiovascular and respiratory limitations that significantly reduce endurance and make leaving the home taxing and unsafe without considerable effort and recovery time. Skilled nursing, physical therapy, and occupational therapy services are indicated to address medication management, respiratory condition education, fall prevention, strength and balance training, safe mobility, and improvement of functional independence. Continued skilled therapy is necessary to reduce fall risk, prevent further functional decline, and support the patient's goal of returning to independent function and eventual return to work.
 Date of Order 04/11/2026 Orders Physician Face-to-Face Date: 04/07/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Pneumonia unspecified organism 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 OT Eval Notes: PT Eval Notes: Physician Villar, Kenneth

SN Careplans

SN WK1: 8 (04/10/26-04/11/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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.
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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, lethargy, balance deficit, B1000 - Vision Deficit, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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

SN Goals

PATIENT-STATED GOAL: To stop my body from aching and build my strength

GOALS
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
* 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
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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

meal preparation is available to patient for all meals

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/11/2026

Home Health Certification and Plan of Care

Order ID: 1150/17903

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47201820800	04/11/2026	From: 04/11/2026 To: 06/09/2026	24689	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Robin Granofsky 3501 KINGSLEY COURT APT A, PASADENA, MD 21122- 410-507-8847	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes 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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 10 (04/10/26-04/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: cough/deep breathing exercises, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To not hurt, and to possibly be able to et back to work.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26) ,WK7: 1 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body

OT Goals

PATIENT-STATED GOAL: not to be in pain able to do everything that pt was doing earlier

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/11/2026

Home Health Certification and Plan of Care

Order ID: 1150/17903

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47201820800	04/11/2026	From: 04/11/2026 To: 06/09/2026	24689	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Robin Granofsky 3501 KINGSLEY COURT APT A, PASADENA, MD 21122- 410-507-8847	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Dressing - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/11/2026