Home Health Certification and Plan of Care

Order ID: 1150/19440

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6CP4DX3RX88	06/06/2026	From: 06/06/2026 To: 08/04/2026	26555	217058

6. Patient's Name and Address
Mark Rockmore
5425 Hildebrand Ct,
Columbia, MD 21044-
301-520-4398

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 12/22/1947 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.817	Encntr for surgical aftcr fol surgery on the skin subcu	06/06/26

13. ICD	Other Pertinent Diagnoses	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	06/06/26
L97.411	Non-prs chr ulcer of right heel and midft lmt to brkdwn skin	06/06/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	06/06/26
I10.	Essential (primary) hypertension	06/06/26
E78.5	Hyperlipidemia unspecified	06/06/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	06/06/26
M81.0	Age-related osteoporosis w/o current pathological fracture	06/06/26
M17.11	Unilateral primary osteoarthritis right knee	06/06/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/06/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/06/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/06/26

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

Ascorbic Acid - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 500 mg/tablet / Give 2 tablet by mouth in the morning for Supplement 2 Tabs= 1000mg
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth once a day prophylactic
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime for HLD
B Complex-C Oral Tablet (B Complex w/ C) 1 Tablet by mouth in the morning for Supplement
Calcium 600 (Calcium Carbonate) 600mg; 1 Tablet by mouth once a day in the afternoon for CALCIUM DEFICIENCY
Docusate Sodium - Docusate Sodium 100 mg / 1 Capsule by mouth at bedtime for Bowel Management
Gabapentin - Gabapentin 100 mg 100 mg / 1 Capsule by mouth twice a day and at bedtime for neuropathic pain
Linzess - Linaclotide 290 mcg / 1 Capsule by mouth as necessary every 24 hours as needed for Constipation
Losartan Potassium - Losartan Potassium 100 mg 100 mg / 1 Tablet by mouth in the evening for HTN
Metformin Hcl - Metformin Hydrochloride 500 mg/tablet / Give 2 tablet by mouth once a day for DM
Milk Of Magnesia - Simethicone Suspension 400 MG/5ML / Give 30 ml by mouth once a day every 24 hours as needed for BOWEL MANAGEMENT
Omega 3 - Cod Liver Oil 1000 mg / 1 Capsule by mouth in the morning for Supplement
Sennosides - Senna 8.6 mg/tablet / Give 2 tablet by mouth every 12 hours as needed for Constipation
Spironolactone - Spironolactone 25 mg 25 mg / 1 Tablet by mouth in the morning for CHF
ACETAMINOPHEN 500 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for PAIN
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 UNIT / 1 Tablet by mouth in the morning for VITAMIN D DEFICIENCY
Fluticasone Propionate - Fluticasone Propionate 0.05 mg/spray Suspension 50 MCG/ACT / 2 spray in each nostril Nasal as necessary every 24 hours as needed for RUNNY NOSE
Flonase Allergy Relief - Fluticasone Propionate 50 MCG/ACT / 1 spray in each nostril Nasal in the morning for ALLERGIC RHINITIS
Mupirocin - Mupirocin 0 Ointment 2 % / Apply to Right Heel wound topical in the morning every Mon, Wed, Fri for WOUND CARE APPLY AFTER CLEANSING WITH NSS, PAT DRY AND WRAP WITH KERLIX M/W/F
Aquaphor Ointment (Emollient) Apply to B/L LE topical every 12 hours as needed for DRY SKIN APPLY AFTER CLEANSING WITH SOAP/WATER AND OR NSS

14. DME and Supplies:
grab bars, bath bench, wound care supplies, diabetic supplies, walker, cane

15. Safety Measures:
standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, sharps precautions, activity supervision

16. Nutrition:
diabetic, cardiac diet,

17. Allergies:
iodinated contrast media sulfa antibiotics cats/cat dander grass pollen ragweed

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Up As Tolerated, Cane, Walker, Exercises Prescribed

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

Homebound status: After undergoing Heterotopic bone excision with soft tissue flap reconstruction, 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.

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/06/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Hummira Abawi
2200 Kernan Dr
Baltimore, MD 21207
PHONE: 4438314884 FAX: 14434413004 NPI: 1073837217

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 : 05/29/2026

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.

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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Mark Rockmore 5425 Hildebrand Ct, Columbia, MD 21044- 301-520-4398	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

Patient is a 78-year-old male admitted to home health services for skilled nursing, physical therapy, and occupational therapy following treatment for a chronic right heel diabetic wound complicated by abscess, cellulitis, and osteomyelitis, status post heterotopic bone excision with soft tissue flap reconstruction. His past medical history is significant for type 2 diabetes mellitus with severe peripheral neuropathy, peripheral vascular disease, hypertension, hyperlipidemia, osteoarthritis, osteoporosis, obstructive sleep apnea requiring CPAP, benign prostatic hyperplasia, right knee pyogenic septic arthritis with effusion, chronic right heel diabetic foot osteomyelitis, and a history of intracranial hemorrhage approximately one year ago. The patient resides with his spouse in a townhouse equipped with a stair lift for access to the upper level; however, he primarily remains on the main floor due to mobility limitations. His spouse assists with activities of daily living and instrumental activities of daily living as needed, and the patient receives aide assistance for showering, personal care, and laundry twice weekly. Upon skilled nursing assessment, the patient was alert and oriented to person, place, and time. He denied pain, shortness of breath, and other acute complaints. Pulmonary assessment revealed bilateral lower lobe crackles on auscultation. The patient reported a good appetite and stated his last bowel movement occurred the previous day without difficulty. Mild bilateral lower extremity edema (+1) was noted. The patient ambulates with a walker for safety and reports consistent use of a heel offloading boot as instructed. Assessment of the right heel revealed a postoperative wound measuring 2.0 cm x 0.2 cm x 0.1 cm with an additional pinpoint opening in close proximity to the primary wound site. Periwound tissue was noted to be macerated. Given the patient's diabetes, peripheral vascular disease, peripheral neuropathy, and history of osteomyelitis, continued close monitoring of wound healing and infection prevention remains essential. The patient reported that the wound has been present for an extended period and originated from a chronic infection. He has a scheduled follow-up appointment with orthopedic surgery on 06/10/2026. Medication reconciliation was completed, and all medications were reviewed with the patient and spouse, including dosage, frequency, indications, and potential side effects. Skilled nursing provided education regarding wound care, infection prevention, medication compliance, edema management, diabetic foot care, and the importance of adhering to follow-up appointments and treatment recommendations. The patient and spouse were receptive to all education and demonstrated understanding of the instructions provided. Physical therapy evaluation identified significant impairments related to prolonged medical complications and deconditioning. The patient presents with bilateral lower extremity weakness, impaired balance, altered gait mechanics, decreased functional endurance, and the ongoing need for protection and offloading of the right heel during mobility activities. Functional limitations include difficulty with bed mobility, transfers, household ambulation, and safe navigation of the home environment. The patient utilizes a walker for community mobility and a wheelchair for longer outdoor distances. These deficits place him at increased risk for falls, delayed wound healing, loss of independence, and potential hospitalization. Skilled physical therapy services are medically necessary to address strength deficits, balance impairments, gait dysfunction, transfer safety, endurance limitations, and fall prevention while maximizing functional independence and protecting the surgical site. Occupational therapy evaluation revealed additional deficits affecting the patient's ability to safely perform activities of daily living. The patient reports sleeping in a recliner and requires moderate assistance with basic activities of daily living. He remains independent with transfers and requires supervision for functional ambulation. The patient also reports chronic left knee joint pain, mild tremors of the left hand, trigger fingers involving the left ring finger and right little finger, and early cataracts affecting both eyes. These impairments contribute to decreased functional performance, increased reliance on caregiver support, and reduced quality of life. Skilled occupational therapy services are indicated to improve independence with activities of daily living, prevent further deconditioning, enhance safety within the home, and improve overall functional outcomes. Education was reinforced regarding fall prevention strategies, safe use of assistive devices, pressure relief and heel offloading techniques, home safety modifications, energy conservation, skin integrity monitoring, and recognition of signs and symptoms of infection, including increased redness, swelling, drainage, warmth, fever, worsening pain, or changes in wound appearance. The patient and spouse were instructed to promptly report any concerning symptoms to the healthcare provider. Skilled nursing services remain medically necessary for ongoing wound assessment and care, infection surveillance, cardiopulmonary monitoring, edema management, medication management, diabetic education, and patient/caregiver instruction. Skilled physical and occupational therapy services are required to address mobility deficits, weakness, impaired balance, gait dysfunction, decreased endurance, reduced independence with activities of daily living, and fall risk through therapeutic exercise, gait and transfer training, balance interventions, functional mobility training, adaptive technique instruction, and home safety education. The overall goal of care is to promote wound healing, maximize functional independence, reduce fall risk, prevent rehospitalization, and improve the patient's overall quality of life while safely remaining in the home environment.
 Date of Order 06/06/2026 Orders Physician Face-to-Face Date: 05/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Heterotopic bone excision with soft tissue flap reconstruction 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: OT Eval Notes:
 Physician Abawi, Hummira

SN Careplans

SN WK1: 1 (06/06/26-06/06/26) ,WK2: 2 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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

SN Goals

PATIENT-STATED GOAL: TO GET BETTER AND HEEL WOUND TO CLOSE

GOALS
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

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

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

patient/caregiver recalls

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/06/2026

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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:ATTEMPT CPR

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, meal preparation, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, balance deficit, Pain Interference with Therapy activities, Pain Interference with ADLs, rough/scaly/cracked skin, #1 - Other - Posterior Right Heel - pale wound bed pin point open area in close proximity of the wound

PROCEDURES: physician-ordered wound care: #1 - Other - Posterior Right Heel - pale wound bedpin point open area in close proximity of the wound: SN/CG TO CLEANSE THE RIGHT HEEL WOUND WITH NSS, PAT DRY, APPLY MUPIROCIN OINTMENT 2%, SKIN PREP TO PERIWOUND FOR MACERATION, COVER WITH DRY DRESSING, WRAP WITH KERLIX AND SECURE WITH TAPE. MON, WED, FRIDAY., physician-ordered wound care: #1 - Other - Posterior Right Heel - pale wound bed pin point open area in close proximity of the wound, coordinate/arrange for maintenance of clean/uncluttered living area

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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK2: 1 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26) ,WK10: 1 (08/02/26-08/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: B LE mm strengthening: 1, B LE mm strengthening: 1, physician-ordered wound care: CLEANSE THE RIGHT HEEL WOUND WITH NSS, PAT DRY, APPLY MUPIROCIN OINTMENT 2%, SKIN PREP TO PERIWOUND FOR MACERATION, COVER WITH DRY DRESSING, WRAP WITH KERLIX AND SECURE WITH TAPE. MON, WED, FRIDAY., home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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 be able to walk safer at home

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

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 Goals

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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OT WK2: 1 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26)

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

PROCEDURES: Tub transfer : TO get in and out of tub, cough/deep breathing exercises, physician-ordered wound care: CLEANSE THE RIGHT HEEL WOUND WITH NSS, PAT DRY, APPLY MUPIROCIN OINTMENT 2%, SKIN PREP TO PERIWOUND FOR MACERATION, COVER WITH DRY DRESSING, WRAP WITH KERLIX AND SECURE WITH TAPE. MON, WED, FRIDAY., home exercise program, equipment training, work simplification/energy conservation

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, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: TO gain PLOF

GOALS
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

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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