Home Health Certification and Plan of Care

Order ID: 1150/20615

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3RF3JR9YM11	07/17/2026	From: 07/17/2026 To: 09/14/2026	28022	217058

6. Patient's Name and Address

Veneshia McCray
3313 Cliftmont Ave,
BALTIMORE, MD 21213
540-841-5454

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 03/02/1963 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	07/17/26

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	07/17/26
E10.22	Type 1 diabetes mellitus w diabetic chronic kidney disease	07/17/26
N18.6	End stage renal disease	07/17/26
D63.1	Anemia in chronic kidney disease	07/17/26
Z99.2	Dependence on renal dialysis	07/17/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	07/17/26
E78.5	Hyperlipidemia unspecified	07/17/26
E10.43	Type 1 diabetes w diabetic autonomic (poly)neuropathy	07/17/26
K31.84	Gastroparesis	07/17/26
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	07/17/26
E27.40	Unspecified adrenocortical insufficiency	07/17/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/17/26
E10.51	Type 1 diabetes w diabetic peripheral angiopath w/o gangrene	07/17/26
M81.0	Age-related osteoporosis w/o current pathological fracture	07/17/26
R13.13	Dysphagia pharyngeal phase	07/17/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/17/26
I95.1	Orthostatic hypotension	07/17/26
N31.9	Neuromuscular dysfunction of bladder unspecified	07/17/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	07/17/26
Z79.01	Long term (current) use of anticoagulants	07/17/26
Z79.82	Long term (current) use of aspirin	07/17/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	07/17/26
Z79.52	Long term (current) use of systemic steroids	07/17/26
Z95.1	Presence of aortocoronary bypass graft	07/17/26
Z95.5	Presence of coronary angioplasty implant and graft	07/17/26
Z94.83	Pancreas transplant status	07/17/26
Z94.0	Kidney transplant status	07/17/26

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

ACETAMINOPHEN 500 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for Pain Equal to 1000mg
AMLODIPINE 2.5 MG / 1 Tablet by mouth one time a day for Radial Graft until 07/22/2026 11:30 (HOLD FOR SBP < 110) As recommended by patients cardiologist. EOT 07/22/2026
ASPIRIN Delayed Release 81 MG / 1 Tablet by mouth in the morning for CAD
ATORVASTATIN 80 MG / 1 Tablet by mouth at bedtime for HLD
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit) / 1 Tablet by mouth in the morning for VITAMIN D DEFICIENCY
CINACALCET HYDROCHLORIDE 30 MG / 1 Tablet by mouth in the morning for Hyperparathyroidism
CLOPIDOGREL 75 MG / 1 Tablet by mouth in the evening for CAD until 05/28/2027 23:59
EZETIMIBE 10 MG / 1 Tablet by mouth at bedtime for HLD
FAMOTIDINE 20 MG / 1 Tablet by mouth two times a day for GERD
GABAPENTIN 100 mg/capsule / Give 2 capsule by mouth two times a day for Neuropathy 2 Caps= 200mg
JARDIANCE 10 MG / 1 Tablet by mouth in the morning for Type 2 DM
LACTULOSE 10 gram/15 mL solution / Give 15 ml by mouth in the morning for BOWEL MANAGEMENT
MELATONIN 10 MG / 1 Capsule by mouth at bedtime for INSOMNIA
Metoclopramide Hcl - Metoclopramide Hydrochloride 10 MG / 1 Tablet by mouth before meals for GI Motility
Metoprolol Tartrate - Metoprolol Tartrate 25 MG / 1 Tablet by mouth two times a day for HTN HOLD MEDICATION IF PULSE < 60 AND/OR SYSTOLIC BLOOD PRESSURE < 110 mmHg
MIDODRINE HYDROCHLORIDE 2.5 MG / 1 Tablet by mouth as needed for SBP <100 with orthostatic symptoms Max 2 doses per day
MIRALAX 17 gram/dose / Give 17 gram by mouth every 24 hours as needed for CONSTIPATION MIX WITH 4 TO 8OZ OF FLUID - BOWEL PROTOCOL STEP 2 IF NO BM IN 48 HOURS
MYCOPHENOLATE MOFETIL 250 MG / 1 Capsule by mouth three times a day for Kidney Transplant
NEPHRO-VITE 0.8 MG / 1 Tablet by mouth in the morning for ESRD
Ondansetron Hydrochloride - Ondansetron Hydrochloride 4 MG / 1 Tablet by mouth every 8 hours as needed for N/V
PANTOPRAZOLE Delayed Release 40 MG / 1 Tablet by mouth one time a day for GERD
PREDNISONE 5 MG / 1 Tablet by mouth one time a day for Immunosuppression due to Kidney Transplant
Sennosides - Senna 8.6 mg/tablet / Give 2 tablet by mouth two times a day for BOWEL REGIMEN
SIMETHICONE Chewable 80 MG / 1 Tablet by mouth every 6 hours as needed for Flatulence
TACROLIMUS 1 MG / 1 Capsule by mouth two times a day for Kidney Transplant Give with 0.5 mg. Total 1.5 mg BID.
Tacrolimus - Tacrolimus 0.5 MG / 1 Capsule by mouth twice a day for Kidney Transplant Give with 1 mg. Total 1.5 mg BID.
Lasix - Furosemide 20 MG / 1 Tablet by mouth as necessary for weight -2lbs IN 24HRS
Sodium Chloride - Sodium Chloride Soluble 1,000 mg/tablet / Give 0.5 tablet by mouth twice a day for Hyponatremia
Probiotic Blend Oral Capsule (Probiotic Product) Give 1 capsule by mouth in the morning for GI Health
sevelamer HCl 800 mg/tablet / Give 2 tablet by mouth after meal for ESRD
SPIRONOLACTONE 25 MG / 5ml by mouth in the morning for HEART FAILURE/EDEMA
Take 5ml daily
Humalog Kwikpen - Insulin Lispro Recombinant 100 unit/mL subcutaneously before meals and at bedtime Inject as per sliding scale: if 150 - 199 = 1 UNIT; 200 - 249 = 3 UNITS; 250 - 299 = 5 UNITS; 300 - 349 = 7 UNITS; 350 - 350 = 8 UNITS - 350 NOTIFY MD, for Type 2 DM

14. DME and Supplies:

walker, diabetic supplies

15. Safety Measures:

standard precautions, fall precautions, diabetic precautions, medication safety, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

John Allen
419 W Redwood St Ste 600
Baltimore, MD 21201
PHONE: 667-214-1515 FAX: 14103283577 NPI: 1023436839

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 : 07/09/2026

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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410-321-8448
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16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
codeine gentamycin hydromorphone oxycodone propoxyphene vancomycin lact

18.A. Functional Limitations
Endurance, Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted
Transfer bed/Chair, Walker, Exercises Prescribed, 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: 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
SN: family/caregiver will be responsible for managing treatment PT and OT: pat

Homebound status:
Due to diagnosis of Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, 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 63-year-old female admitted to home health services following hospitalization and subacute rehabilitation after CABG 3 for coronary artery disease. Her past medical history is significant for diabetes mellitus status post pancreas transplant, end-stage renal disease status post kidney transplant (1998), congestive heart failure, hypertension, hyperlipidemia, adrenal insufficiency, COPD, hypotension, and a history of TIA. The patient is alert and oriented 4, with vital signs within normal limits and no acute distress. She lives alone in a two-story home with five steps to enter and the bedroom and bathroom located on the second floor, receiving regular assistance from a close friend as needed. Medication reconciliation was completed, and the patient reported she is not currently taking insulin, stating she had not required it prior to her recent hospitalization; she has a scheduled follow-up appointment with her provider to determine whether insulin therapy should be resumed. Skilled nursing provided education on blood glucose monitoring, recognition and management of hypo- and hyperglycemia, insulin administration, medication adherence, diabetic diet, infection prevention related to immunosuppression following kidney and pancreas transplantation, heart failure management including daily weights and monitoring for fluid overload, blood pressure monitoring, fall prevention, energy conservation, and the importance of attending follow-up appointments, with the patient verbalizing understanding. Functionally, the patient ambulates 25 feet indoors without an assistive device under supervision, negotiates 14 stairs with a handrail using a step-to pattern under supervision, demonstrates independent bed mobility, and requires supervision for transfers. She is homebound due to the considerable effort and assistance required to leave the home, with a Tinetti Balance and Gait Assessment score of 17/28 indicating an increased fall risk. She tolerated lower extremity therapeutic exercises, including supine, seated, and standing strengthening activities, and was provided with a written home exercise program to be performed daily. Occupational therapy evaluation noted the patient has returned to independence with basic self-care, functional transfers, and household ambulation; therefore, no further skilled OT services are indicated, while continued skilled nursing and physical therapy are recommended for medication management, disease education, monitoring of chronic conditions, strengthening, balance training, stair negotiation, and improving functional mobility to reduce the risk of rehospitalization and maximize independence.
<o:p></o:p> Date of Order<o:p></o:p> 07/17/2026<o:p></o:p> Physician Face-to-Face Date: 07/09/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>   1 - SOC - SN Notes: <o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes: <span style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';

Signature of Physician:

Date

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

Date
07/17/2026

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font-size:11.0000pt;mso-font-kerning:1.0000pt;"><o:p></o:p> <span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">Physician:<span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;"> Allen, John

SN Careplans

SN WK1: 1 (07/17/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26)

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

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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.
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, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, limited endurance, limited strength, balance deficit, Pain Effect on Sleep, B1000 - Vision Deficit, obesity

PROCEDURES: glucose testing via monitor, monitor intake & output, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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 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, * urinary incontinence management including bladder training Kegel exercises skin care, 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's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and regain strength

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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/17/2026

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PT WK2: 1 (07/19/26-07/25/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26)

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: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training on uneven surfaces, 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

PATIENT-STATED GOAL: Be independent in my house and outside without the walker

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 WK1: 1 (07/17/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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

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 - 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 Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
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

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:
Electronically Signed by Messick, Charles RN

Date
07/17/2026