Home Health Certification and Plan of Care

Order ID: 1150/20704

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
371292669	07/20/2026	From: 07/20/2026 To: 09/17/2026	28270	217058

6. Patient's Name and Address

Charlotte Stella
301 HUNTSMAN CT,
BEL AIR, MD 21015-
443-722-9242

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 02/07/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G30.9	Alzheimer's disease unspecified	07/20/26

13. ICD	Other Pertinent Diagnoses	Date
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	07/20/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/20/26
N18.31	Chronic kidney disease stage 3a	07/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/20/26
E78.2	Mixed hyperlipidemia	07/20/26
E02.	Subclinical iodine-deficiency hypothyroidism	07/20/26
E04.1	Nontoxic single thyroid nodule	07/20/26
G25.81	Restless legs syndrome	07/20/26
G43.909	Migraine unsp not intractable without status migrainosus	07/20/26
N32.81	Overactive bladder	07/20/26
M51.17	Intvrt disc disorders w radiculopathy lumbosacral region	07/20/26
I70.0	Atherosclerosis of aorta	07/20/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/20/26
M79.7	Fibromyalgia	07/20/26
M54.12	Radiculopathy cervical region	07/20/26
H91.93	Unspecified hearing loss bilateral	07/20/26
M85.80	Oth disrd of bone density and structure unspecified site	07/20/26
M54.81	Occipital neuralgia	07/20/26
E55.9	Vitamin D deficiency unspecified	07/20/26
M19.90	Unspecified osteoarthritis unspecified site	07/20/26
M54.40	Lumbago with sciatica unspecified side	07/20/26
K59.00	Constipation unspecified	07/20/26
Z79.82	Long term (current) use of aspirin	07/20/26
Z79.890	Hormone replacement therapy	07/20/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	07/20/26
Z85.118	Personal history of malignant neoplasm of bronchus and lung	07/20/26
Z86.0100	Personal history of colonic polyps	07/20/26
Z96.653	Presence of artificial knee joint bilateral	07/20/26
Z87.891	Personal history of nicotine dependence	07/20/26

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

TOPAMAX 100 MG / 1 Tablet by mouth 2 times a day
NAMENDA 10 MG / 1 Tablet by mouth 2 times a day
LIPITOR 80 MG / 1 Tablet by mouth daily for cholesterol
CYMBALTA Delayed Release 60 MG / 1 Capsule by mouth 2 times a day
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit)/tablet / Take 2 tablets by mouth daily
Synthroid - Levothyroxine Sodium 25 MCG / 1 Tablet by mouth every morning 30 minutes before a meal
ASPIRIN Chewable 81 MG / 1 Tablet by mouth once a day
Multivitamin-Minerals 1 Tablet by mouth once a day
Flonase Allergy Relief - Fluticasone Propionate 50 mcg/actuation Nasl SpSn / Use 1 spray each nostril Nasal once a day

14. DME and Supplies:

rolling walker, hand held shower, bath bench, walker, grab bars, cane, 4 wheeled walker

15. Safety Measures:

standard precautions, seizure precautions, hand rails, fall precautions, ambulates with device, walker precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, medical alert/lifeline, cardiac precautions, bathroom safety, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

Gabapentin; Nsaids, Non-selective [Non-steroidal Anti-inflammatory Agents]; Su

18.A. Functional Limitations

Ambulation, Hearing, Bowel/Bladder Incontinence, Endurance!Dyspnea With Minimal Exertion

18.B. Activities Permitted

Up As Tolerated, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions), HISTORY OF DEPRESSION: No

20. Prognosis: Fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Alzheimer's disease unspecified, 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 07/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Rosina Shrestha
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: FAX: NPI: 1760895346

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 : 07/16/2026

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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Charlotte Stella 301 HUNTSMAN CT, BEL AIR, MD 21015- 443-722-9242	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

Prior to the scheduled skilled nursing visit, the registered nurse contacted the patient's caregiver to confirm the appointment. The caregiver requested that the visit be rescheduled to Monday due to her work schedule, and the request was accommodated. Skilled nursing admission was completed for comprehensive assessment, medication management, chronic disease management, pain assessment, safety evaluation, and patient/caregiver education. The patient is an 83-year-old female with a past medical history significant for senile dementia of the Alzheimer's type, cognitive impairment, chronic kidney disease, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), chronic pain secondary to osteoarthritis, chronic low back pain with sciatica and radiculopathy, gastroesophageal reflux disease (GERD), and chronic rhinorrhea. The patient resides in the basement apartment of her daughter's two-story home with her daughter and son-in-law, who provide supervision, assistance with daily care, and medication management. The patient was alert with baseline cognitive impairment and demonstrated poor short-term memory, repeating herself throughout the visit; however, no acute changes in cognitive status were noted. A comprehensive nursing assessment was completed. Medication reconciliation and a thorough medication review were performed after the family expressed concerns regarding polypharmacy. The current medication regimen was reviewed with both the patient and caregiver, who verbalized understanding of medication indications, dosing, administration, and potential side effects. The patient denied difficulty taking medications and reported no adverse medication effects. Education was reinforced regarding medication adherence and the importance of monitoring for adverse effects. Cardiovascular and respiratory assessments were completed. Hypertension appeared well controlled, with reported home blood pressure readings averaging approximately 117/72 mmHg and a blood pressure of 102/80 mmHg obtained during today's visit. The patient denied dizziness, chest pain, palpitations, headaches, shortness of breath, or other cardiopulmonary symptoms. Persistent rhinorrhea continues despite intermittent use of fluticasone nasal spray and loratadine as needed; however, no signs of respiratory distress or acute infection were observed. GERD remains well controlled with pantoprazole administered every 72 hours, and the patient denied heartburn, reflux, nausea, or epigastric discomfort. Pain assessment revealed chronic low back pain with sciatica and chronic neck pain that are adequately managed with the current medication regimen. The family wishes to continue the existing pain management plan. Functional mobility and fall risk assessments were completed. The patient ambulates with a single-point cane indoors and a rollator for community mobility, demonstrating a slow but steady gait. She avoids stair negotiation unless accompanied due to fall risk and requires assistance with stair navigation and some activities of daily living. No recent falls were reported. Skin assessment revealed intact skin without open wounds, pressure injuries, or edema. The patient remained in no acute distress throughout the visit and tolerated the assessment well. Patient and caregiver education included medication adherence, blood pressure monitoring, chronic disease management, pain management strategies, fall prevention, home safety, and ongoing supervision related to cognitive impairment. Reinforcement was provided regarding the importance of promptly reporting changes in cognition, increased pain, falls, respiratory symptoms, or other significant changes in medical status to the healthcare provider. A skilled physical therapy evaluation was completed following referral after a physician visit. Prior to the recent decline, the patient ambulated with a single-point cane, was independent with transfers, and required assistance with stair negotiation and some activities of daily living. Evaluation findings demonstrated impaired functional mobility characterized by poor short-term memory, lower extremity weakness, impaired balance, unsteady gait with a single-point cane, and difficulty negotiating stairs. Objective balance testing revealed a Tinetti score of 16/28, indicating a high fall risk, and a Timed Up and Go (TUG) score of 36.8 seconds, reflecting significantly impaired mobility and increased fall risk. The patient demonstrates good rehabilitation potential and would benefit from skilled physical therapy interventions to improve lower extremity strength, balance, gait, stair negotiation, safety awareness, endurance, and overall functional mobility to reduce fall risk and maximize independence. A skilled occupational therapy evaluation was also completed following the recent Kaiser medication review. Prior to the current episode, the patient resided with her daughter in the basement mother-in-law suite of a multilevel home and completed basic self-care, functional transfers, and household ambulation using a cane or rollator. At the time of evaluation, the patient was functioning at a supervision level for basic self-care, functional transfers, and household ambulation using a single-point cane. Memory deficits require ongoing supervision during self-care activities; however, the patient was determined to be functioning at her baseline level for occupational performance. No additional skilled occupational therapy services are indicated at this time. Continued skilled physical therapy is recommended to address deficits in stair negotiation, balance, gait, and fall prevention. The patient remains homebound due to impaired mobility, chronic pain, cognitive impairment associated with Alzheimer's dementia, lower extremity weakness, impaired balance, increased fall risk, and the need for assistive devices and caregiver assistance to safely leave the home. The plan is to continue skilled nursing services for ongoing assessment and management of chronic conditions, medication management and monitoring for adverse effects, blood pressure monitoring, pain assessment, cognitive status monitoring, fall prevention, patient and caregiver education, safety monitoring, and coordination of care with the primary care provider.
 Date of Order 07/20/2026 Orders Physician Face-to-Face Date: 07/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha due to Alzheimer's disease unspecified 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 Shrestha, Rosina

SN Careplans

SN WK1: 1 (07/20/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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

SN Goals

PATIENT-STATED GOAL: Caregiver wants patient to regain her independence back and regain her strength to be able to walk safely in her home.

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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
* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026

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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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1700 - Cognition, M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M1400 - Dyspnea, M1033 - Exhaustion, constipation, frequent urination, M1600 - UTI, M1610 - Urinary Incontinence, limited endurance, limited strength, muscle weakness, B0200 - Hearing Deficit, weak hand grips, balance deficit, difficulty sleeping, daytime fatigue, obesity

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * 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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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 hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 6 (07/19/26-07/25/26) ,WK2: 6 (07/26/26-08/01/26)

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: Medication management : Review medication with patients family members, home exercise program: Seated Extension hip flexion, hip abduction, he'll raises toe raises, Steaming exercises as tolerated for heel raises tow raises hip flection.hamstring curls, home exercise program: Seated Extension hip flexion, hip abduction, he'll raises toe raises, Steaming exercises as tolerated for heel raises tow raises hip flection.\nHamstring curls, dynamic standing balance exercises: Perform dynamic balance training exercises to improve patient reaction time, weight shifting to improve stability and reduce risk for falls., gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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 get better shape and prove my strength and balance walk easier;To get better shape and improve my strength and balance walk easier

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

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/20/2026

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OT WK1: 4 (07/19/26-07/25/26) ,WK2: 4 (07/26/26-08/01/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, 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: Evaluation only

GOALS
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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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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