Home Health Certification and Plan of Care

Order ID: 1150/21727

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32714760	09/01/2026	From: 09/01/2026 To: 10/30/2026	29527	217058

6. Patient's Name and Address

James Rooary
2833 W Lanvale St,
BALTIMORE, MD 21216-
443-273-6750

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 04/20/1932 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.623	Pressure ulcer of left heel stage 3	09/01/26

13. ICD	Other Pertinent Diagnoses	Date
L89.612	Pressure ulcer of right heel stage 2	09/01/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	09/01/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/01/26
N18.4	Chronic kidney disease stage 4 (severe)	09/01/26
E78.5	Hyperlipidemia unspecified	09/01/26
E03.9	Hypothyroidism unspecified	09/01/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	09/01/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	09/01/26
D50.9	Iron deficiency anemia unspecified	09/01/26
E55.9	Vitamin D deficiency unspecified	09/01/26
K21.9	Gastro-esophageal reflux disease without esophagitis	09/01/26
N28.1	Cyst of kidney acquired	09/01/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	09/01/26
Z79.01	Long term (current) use of anticoagulants	09/01/26
Z79.4	Long term (current) use of insulin	09/01/26
Z79.890	Hormone replacement therapy	09/01/26
Z79.891	Long term (current) use of opiate analgesic	09/01/26

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

ACETAMINOPHEN 325 MG Tablet / Give 3 tablet by mouth every 8 hours for pain mangement
Apixaban 2.5 MG / 1 Tablet by mouth twice a day for prophylaxis hx of TIA
ERGOCALCIFEROL 1.25 MG (50000 UT) / 1 Capsule by mouth one time a day every Sat for Vit d def for 8 Weeks
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide Inhalation Solution 0.5-2.5 (3) MG/3ML / Inhale 1 Vial by mouth as necessary every 8 hours for Asthma Pre and Post Tx Lung Sounds C= Clear 0=Other (see Progress Note) Pre and Post Tx- P, R and 02 Sat Results MNS- Enter the number of minutes the of nurse time for the medication Administration
Iron - Ferrous Sulfate: Folic Acid 325 MG / 1 Tablet by mouth as directed every 48 hours for IDA
Levothyroxine Sodium - Levothyroxine Sodium 75 MCG / 1 Tablet by mouth one time a day for hypothyroidism
MULTIVITAMIN Give 1 tablet by mouth one time a day for supplement
Norvasc - Amlodipine Besylate 10 MG / 1 Tablet by mouth one time a day for hypertension hold if sbp is less than 110 or pulse is less than 60
Pravastatin Sodium - Pravastatin Sodium 40 MG / 1 Tablet by mouth one time a day for hypercholesterolemia
Tramadol Hcl - Tramadol Hydrochloride 25 MG / 1 Tablet by mouth every 6 hours as needed for pain
Trazodone Hydrochloride - Trazodone Hydrochloride 100 MG / 1 Tablet by mouth one time a day for Depression
GABAPENTIN 600 mg 600 MG / 1 Capsule by mouth one time a day for Nerve Pain
FLOMAX 0.4 MG / 1 Capsule by mouth one time a day for bph
Insulin Lispro (1 Unit Dial) Solution Pen-injector 100 UNIT/ML SS subcutaneous before meal and at bedtime for diabetes. Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units Call physican if blood sugar is less 60 or greater than 400,
Xerotorm One application topical every other day For wound care

14. DME and Supplies:

bath bench, commode, hospital bed, diabetic supplies, wound care supplies, walker, wheelchair

15. Safety Measures:

transfer with assist, walker precautions, supervision at all times, standard precautions, medication safety, diabetic precautions, fall precautions, bathroom safety, ambulates with device, activity supervision, ambulates with assistance

16. Nutrition:

renal diet, low cholesterol, diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Partial Weight Bearing, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, 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: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

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

Homebound status: Due to diagnosis of Pressure ulcer of left heel stage 3, 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:

Start of care (SOC) completed for a 94-year-old male with a significant past medical history including bilateral heel pressure ulcers, type 2 diabetes mellitus, hypertensive kidney disease/CKD, hyperlipidemia, hypothyroidism, benign prostatic hyperplasia (BPH), peripheral neuropathy, vitamin D deficiency, GERD, renal cyst, history of TIA, anemia, dementia/forgetfulness, decreased right knee range of motion, and long-term use of anticoagulant therapy, insulin, opioid medication, and hormone replacement therapy. The patient was recently hospitalized due to CKD and decreased mobility and has since returned home. The patient resides in a single-family home with his two daughters and other family members. Daughters Ivy, who is the POA, and Barbara provide primary caregiving and assistance with the patient's daily needs. The home has a ramp for exiting, and a first-floor setup has been established with a hospital bed and commode due to the patient's significant mobility limitations. Available durable medical equipment includes a hospital bed, walker, wheelchair, commode, and shower chair. SOC calendar and medication sheet were completed for quick reference, and required consents were signed by the caregiver. Insurance verification was completed, and per caregiver report, no other home health agency is currently providing services in the home. The patient is noted to be very forgetful with cognitive impairment/dementia and requires extensive caregiver support. He reports significant bilateral foot pain associated with peripheral neuropathy, particularly at night, with pain reported as 8-9/10 and described as severe enough to awaken him from sleep. The patient was instructed regarding the 0-10 pain scale and that a pain level of 10/10 represents an emergency requiring appropriate medical attention. Bilateral heel pressure ulcers were assessed. The left heel wound is open, measuring approximately 2.0 0.1 cm, with clear fluid drainage and moderate edema present. Wound photographs were obtained. Ordered wound care consists of cleansing the affected area, patting dry, applying Xeroform, and covering with Kerlix, with dressing changes three times weekly. Necessary wound care supplies identified for ordering include Kerlix, Xeroform, tape, medium gloves, drapes, 4 4 gauze, and wound cleanser. Caregiver was instructed on

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 09/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Anuradha Reddy
821 N Eutaw St
Baltimore, MD 21201
PHONE: 4102258153 FAX: 14104625079 NPI: 1760559009

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 : 08/17/2026

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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pressure-relief measures and elevation of the lower extremities to help reduce the noted +2 edema. The patient was also instructed to use heel cups while sitting or lying to minimize pressure to the heels and promote wound healing. The patient has type 2 diabetes mellitus and requires caregiver assistance with disease management and insulin administration. A random blood glucose level of 225 mg/dL was obtained after the patient consumed cereal, juice, and a sandwich. The insulin schedule was reviewed with the caregivers, and education was provided regarding diabetes management and proper insulin administration. Caregivers were instructed to monitor blood glucose as ordered, administer insulin according to the prescribed regimen, and report significant or persistent changes in blood glucose or other concerning symptoms to the healthcare provider. The patient is also receiving long-term anticoagulation therapy. No abnormal bleeding was reported or observed. Caregiver education was provided regarding anticoagulant therapy, potential adverse effects, <hility is-highlighty="true" role="mark" data-hility="93032137-0230-4c13-a00b-e29ab027a8f4" data-hility-name="bleeding precautions" data-hility-match="highlight-pass-8:1" data-decoration-type="background" style="--decoration-thickness: auto;">bleeding precautions</hility>, and the importance of monitoring for and promptly reporting signs of abnormal bleeding. Bowel status was assessed, with the patient's last bowel movement reported as yesterday and positive bowel sounds present. No abnormal lung sounds were noted, and vital signs were stable at the time of assessment. The patient demonstrates substantial functional limitations and requires maximum assistance with mobility due to bilateral heel wounds, generalized weakness, decreased endurance, cognitive impairment, and right knee dysfunction. During the PT evaluation, the patient required maximum assistance for bed mobility, including transitioning from supine to sitting. Once seated at the edge of the bed, he was able to maintain the position for approximately 10 minutes with supervision. Sit-to-stand transfer from the bed required moderate assistance, and transfer from the bed to the wheelchair was completed using a stand-pivot technique with a walker and moderate assistance. Ambulation was not attempted during the evaluation due to the patient's significant functional limitations and safety concerns related to the heel wounds and weakness. The patient was left sitting upright in the wheelchair following the session. He demonstrated significant difficulty bending the right knee, which further complicated transfers. Therapeutic exercises were initiated, including 10 repetitions each of knee extension and ankle pumps, which the patient tolerated. The patient and caregivers report a recent decline in participation and mobility, with the patient having become increasingly inactive over the preceding several days. His daughters reported difficulty getting him out of bed and expressed significant caregiver burden, with one daughter stating that she feels overwhelmed and is unable to continue managing the current level of care without additional support. Education was provided regarding the importance of gradually increasing safe activity and fluid intake as appropriate to help prevent dehydration. The patient and caregivers were instructed in pressure-relief strategies, including consistent use of heel cups and appropriate positioning to reduce pressure on the heels while sitting or lying. Fall-prevention and safety precautions were reinforced due to the patient's severe mobility limitations, cognitive impairment, weakness, and need for assistance with transfers. The patient is considered homebound due to significant difficulty and considerable effort required to leave the home, impaired mobility, bilateral heel pressure ulcers, generalized weakness, decreased right knee range of motion, unsteady functional mobility, and need for substantial assistance from caregivers and an assistive device. His Tinetti score of 3/28 further demonstrates a very high risk for falls and significant impairment in balance and mobility. Skilled home health services are medically necessary for wound assessment and management, monitoring of diabetes and anticoagulation therapy, medication education, pain and symptom monitoring, prevention of complications, and caregiver education. Physical and occupational therapy services have been ordered to address impaired strength, balance, transfers, bed mobility, functional mobility, activities of daily living, safety awareness, and caregiver training. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> at a frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 3 weeks (SN 2W3), with continued therapy and interdisciplinary monitoring to promote wound healing, improve functional independence and safety, reduce fall risk, and prevent further functional decline and caregiver burden.
 Date of Order 09/01/2026 Orders Physician Face-to-Face Date: 08/17/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Pressure ulcer of left heel stage 3 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:
 Physician Reddy, Anuradha

SN Careplans	SN Goals
SN frequency WK1: 2 (09/01/26-09/05/26) ,WK2: 2 (09/06/26-09/12/26) ,WK3: 2 (09/13/26-09/19/26)	PATIENT-STATED GOAL: To walk again without pain
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, blood sugar < 60 > 300	GOALS patient/caregiver recalls * how to achieve wound healing including cleaning and dressing wound * position changes * skin care * diet modification * record wound measurements * recalls related medication(s) purpose, schedule
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance	
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications	
STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; 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 ; 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.	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
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.	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
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	caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence
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.	patient/caregiver recalls * how to keep home safe for patient with dementia * coping strategies for the caregiver* recalls related medication(s) purpose, schedule
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	patient self-administers medications as prescribed
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.	* recalls related medication(s) purpose, schedule
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques	patient is adequately supervised

Signature of Physician:	Date
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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.

Left heel stage 2 pressure ulcer 2x0.2x0.1cm cleanse area pat dry apply xerofoam cover with Kerlix (and secure with tape); 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.

Left heel stage 2 pressure ulcer 2x0.2x0.1cm cleanse area pat dry apply xerofoam cover with Kerlix (and secure with tape) Tuesdays Thursdays and Saturdays
Advance Directive:Ivy Rooary 443 273 6750

09/05/2026 Problems : #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Right Heel -
#2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Heel - No open wounds noted
loss of appetite (NU)
M1700 - Cognition
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
weak pulses in feet
swelling in the arms/legs
abn cholesterol > 200 mg/dL
abnormal blood pressure
extremity burn/tingle/numb
difficulty sleeping
balance deficit
pain radiating to arms/legs
muscle weakness
swelling of affected area
limited endurance
limited strength
bruising/discoloration
open sores/lesions
red/tender pressure points
abnormal thyroid <> 0.40 - 4.50 mIU/mL
abnormal BS < 70/140 > mg/dL
meal preparation
M2102c - Med Admin
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: physician-ordered wound care: #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Right Heel -: Left heel stage 2 pressure ulcer 2x0.2x0.1cm cleanse area pat dry apply xerofoam cover with Kerlix (and secure with tape), physician-ordered wound care: #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Heel - No open wounds noted: No open wounds noted, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

meal preparation is available to patient for all meals

Signature of Physician:	Date
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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 keep home safe for patient with dementia coping strategies for the caregiver*, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, 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 frequency WK1: 1 (09/01/26-09/05/26) ,WK2: 1 (09/06/26-09/12/26) ,WK3: 2 (09/13/26-09/19/26) ,WK4: 1 (09/20/26-09/26/26) ,WK5: 1 (09/27/26-09/30/26)

09/03/2026 Problems : GG0170I1 - Walk 10 Feet
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170J1 - Walk 50 ft with 2 Turns
GG0170K1 - Walk 150 Feet
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170D1 - Sit to Stand
GG0170P1 - Picking Up Object
GG0170E1 - Chair to Bed to Chair
GG0170G1 - Car Transfer
GG0170N1 - 4 Steps
GG0170O1 - 12 Steps
GG0170M1 - 1 - Step (curb)
GG0170S1 - Wheel 150 feet
GG0170R1 - Wheel 50 ft w 2 Turns
GG0170F1 - Toilet Transfer

PROCEDURES: Family training: Bed mobility, transfers, positioning, gait, Gait training with rolling walker: Rolling walker to assist, wheelchair training, home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Sitting knee extension, ankle pumps, equipment training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 03. Partial/moderate assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: To walk again inthe house with my walker

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

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

Toilet Transfer - 03. Partial/moderate assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

1 - Step (curb) - 02. Substantial/maximal assistance

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Signature of Physician:	Date
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