HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022060

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
281009383	09/11/2026	09/11/2026 - 11/09/2026	30070	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Annie Hawkins 9075 Thamesmeade Rd unit J Laurel, MD 20723	Female	02/22/1938	202-749-7955
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

Miss Annie Hawkins is an 88-year-old female who lives with her daughter and granddaughter in a second-floor apartment requiring negotiation of multiple stairs to enter. Approximately three weeks prior to hospitalization, the patient experienced acute distress, chest tightness, dizziness, and syncope while shopping with her family, prompting a 911 call and transport to Johns Hopkins Howard County General Hospital. She was subsequently transferred to Lorien Columbia SNF on 8/26/2026 for subacute rehabilitation and discharged home on 9/9/2026. Her admission diagnosis was cerebral infarction with hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side. Her medical history is significant for recent acute ischemic stroke treated with TNK thrombolysis, persistent left-sided weakness, diplopia, chronic vertigo/imbalance, cervical radiculopathy, cervical spinal stenosis, essential hypertension, hyperlipidemia, hypomagnesemia, prediabetes, hypothyroidism, hyperparathyroidism, chronic constipation, cerebrovascular disease, and Arnold-Chiari malformation status post brain surgery. Following the stroke, the patient demonstrated persistent left-sided weakness and diplopia, with cervical radiculopathy confirmed by cervical MRI and treated with gabapentin and a prednisone taper. During SNF rehabilitation, she reported bilateral plantar foot pain and lower-extremity tenderness, with decreased bilateral pedal pulses; arterial Doppler studies were requested to evaluate for possible peripheral arterial disease. Upon returning home, the patient continues to report generalized and left-sided weakness, intermittent vertigo, diplopia, left lower-extremity numbness/tingling, and shortness of breath when climbing stairs. She presents with lower-extremity strength approximately 3+/5 to 4-/5, impaired dynamic balance, decreased coordination and activity tolerance, altered gait mechanics, and increased fall risk. The patient has a history of multiple falls, including more than four falls in the past year, and currently demonstrates difficulty with safe transfers, household ambulation,

Physician Statement on Homebound Status:

Due to diagnosis of Hemiplegia following cerebral infarction affecting left dominant side, 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

cooking, laundry, and other activities of daily living, occasionally stumbling or running into objects due to impaired balance, vision, and coordination. She previously ambulated with a cane due to chronic vertigo/imbalance and currently requires an appropriate assistive device and caregiver assistance for safe mobility. Skilled home health nursing is indicated for disease-process education, medication management, fall-prevention education, dietary teaching, and monitoring for signs and symptoms requiring physician notification, while skilled HHPT is indicated for progressive strengthening, balance and gait training, transfer training, fall prevention, pacing, and safe progression toward independent household mobility. Skilled OT is also indicated to address left upper-extremity weakness, coordination deficits, visual/perceptual limitations, and decreased independence with functional activities. The patient is considered homebound due to weakness, impaired balance, gait instability, decreased activity tolerance, and the considerable and taxing effort required to leave the home.<o:p></o:p>

Date of Order<o:p></o:p>
09/11/2026<o:p></o:p>
Physician Face-to-Face Date:
09/02/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Hemiplegia following cerebral infarction affecting left dominant side<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: <o:p></o:p>
Physician: Tamrat, Yonas

ICD-10 CM Principal Diagnosis: I69.352. Hemiplga following cerebral infrc aff left dominant side

Other Pertinent Diagnoses

ICD-10 CM	Description
I69.398	Other sequelae of cerebral infarction
H53.2	Diplopia
I69.393	Ataxia following cerebral infarction
I10.	Essential (primary) hypertension
E78.49	Other hyperlipidemia
M48.02	Spinal stenosis cervical region
M54.12	Radiculopathy cervical region
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
E03.9	Hypothyroidism unspecified
E21.3	Hyperparathyroidism unspecified
M79.671	Pain in right foot
M79.672	Pain in left foot
M25.512	Pain in left shoulder
H81.399	Other peripheral vertigo unspecified ear
E83.42	Hypomagnesemia

Medications

Voltaren - Diclofenac Sodium 0 Arthritis Pain 1 % Top Gel / APPLY 2 GRAMS TO L SHOULDER transdermally two times a day for Pain
Synthroid - Levothyroxine Sodium 88 MCG / 1 Tablet by mouth one time a day for Hypothyroidism BEFORE BREAKFAST
PREDNISONE 10 mg 10 MG Tablet / Give 3 tablet by mouth in the morning for NEURITIS for 3 Days TAKE WITH FOOD TO PREVENT GI UPSET
MECLIZINE 12.5 MG / 1 Tablet by mouth every 12 hours as needed for VERTIGO EVERY 12 HOURS PRN
Magnesium Hydroxide - Magnesium Hydroxide suspension 400 mg/5 mL / Give 30 ml by mouth as necessary every 24 hours CONSTIPATION IF NO BM IN 2 DAYS
MAGNESIUM GLYCINATE 100 MG / 1 Capsule by mouth in the morning for HYPOMAGNESEMIA
LOSARTAN POTASSIUM 100 MG / 1 Tablet by mouth in the morning for HTN HOLD MEDICATION IF SYSTOLIC BLOOD PRESSURE < 110 mmHg
GABAPENTIN 100 MG Capsule / Give 2 capsule by mouth two times a day for Neuropathy equal to 200mg
CINACALCET HYDROCHLORIDE 30 MG / 1 Tablet by mouth in the morning for Hyperparathyroidism
BARRIER CREAM - topically as necessary Apply to PERI AREA AND BUTTOCKS every 1 hours for Skin Protection AFT CLEANS SOAP/WATER

K59.09	Other constipation	ATORVASTATIN 20 MG / 1 Tablet by mouth at bedtime for HLD
R40.0	Somnolence	ASPIRIN 0 Chewable 81 MG / 1 Tablet by mouth in the morning for CAD
R73.03	Prediabetes	AMLODIPINE 10 MG / 1 Tablet by mouth in the morning for HTN HOLD FOR SBP < 110
Z79.82	Long term (current) use of aspirin	ACETAMINOPHEN 325 MG Tablet / GIve 2 tablet by mouth every 8 hours as needed for MILD TO SEVERE PAIN for TEMP > 99
Z87.891	Personal history of nicotine dependence	

Prognosis fair	**Mental and Psychosocial 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: 3. During the day and evening, but not 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, HISTORY OF DEPRESSION: No
Functional Limitations Ambulation, Endurance, Bowel/Bladder Incontinence	**Activities Permitted** Walker, Up As Tolerated
DME & Supplies bath bench, walker, cane	**Safety Measures** fall precautions, walker precautions, ambulates with device, transfer with assist, ambulates with assistance, standard precautions, cardiac precautions
Nutrition low cholesterol, cardiac diet	**Allergies** no known allergies

Advance Directives
No Advance Directive

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance

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

DISCHARGE PLAN:
SN and PT: patient will be responsible for managing treatment

OT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/11/26-09/12/26),WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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, 9. Other risk(s) not listed in 1- 8

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ;
Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

09/13/2026 Problems : A1250 - Lack of Necessary Transportation
M1700 - Cognition

SN NARRATIVE

Miss Annie Hawkins is 88 years old female, who live with her daughter and grandchildren in apartment, on second floor with many steps leading to apartment. Patient reported that she was out with her family x3 wks ago shopping, when she started having distress, chest tightness, and passing out, 911 was call and was taken to John Hopkins Howard County General Hospital, then transfer to Lorien Columbia (SNF) 8/26/26, discharge home 9/9.

admission DX: CEREBRAL INFARCTION, with HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION, AFFECTING LEFT DOMINANT SIDE

Patient with H/O: HYPERLIPIDEMIA, HYPOMAGNESEMIA, DIPLOPIA, ESSENTIAL (PRIMARY) HYPERTENSION, RADICULOPATHY. On assessment Patient c/o left side weakness, generalize weak, double vision, vertigo, patient forgetful. Daughter reported several fall pre-hospitalization due vertigo, patient high risk for fall r/o disease process, patient reported pain in the soles of her bilateral feet with tenderness bilateral lower extremities. Sn educated Patient on fall precaution, stand by assist, use walker when going out, cane in apartment due to limited space, educated that PT/OT will f/u for evaluation, sn 1x/wk due for disease process teaching, medication, fall precaution, diet teaching.

SN GOALS

PATIENT-STATED GOAL: Improve strength

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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
* avoiding known stressors
* controlling impulses
* 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

M1720 - Anxiety
M1610 - Urinary Incontinence
M1033 - Exhaustion
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dizziness/syncope
extremity burn/tingle/numb
balance deficit
weak hand grips
limited endurance
muscle weakness
limited strength
bruising/discoloration
B1000 - Vision Deficit
meal preparation
M1745 - Behavioral Issues

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, bladder training, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms, coordinate/arrange transportation services

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, * 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 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, meal preparation is available to patient for all meals

* diet
* recalls related medication(s) purpose, schedule

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

patient's transportation needs are met

meal preparation is available to patient for all meals

OT CAREPLAN

OT frequency WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26),WK6: 1 (10/11/26-10/17/26),WK7: 1 (10/18/26-10/24/26),WK8: 1 (10/25/26-10/31/26)

09/17/2026 Problems : 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: cough/deep breathing exercises, incentive spirometer, home exercise program: Deep breaths, shoulders, wrist, elbow, fix meals, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 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, 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 NARRATIVE

Pt is a 88 yo female, Previously, the patient was hospitalized for an acute ischemic stroke presenting with acute onset dizziness, left-sided weakness, diplopia, and ataxia, treated with TNK thrombolysis. Neurologic deficits improved during hospitalization, though persistent left-sided weakness and diplopia remained at discharge. She developed cervical radiculopathy during her hospital stay, confirmed by MRI of the cervical spine, managed with gabapentin and a prednisone taper. She was discharged to Lorien Columbia for subacute rehabilitation with the goal of progressing well with rehab services. During snf stay - patient notes pain in the soles of her bilateral feet with some tenderness to palpation in the bilateral lower extremities. Examination is notable for decreased bilateral lower extremity pedal pulses. Arterial Dopplers have been requested for further evaluation of possible peripheral arterial disease. Pt was dc home, lives with her daughter and grand daughter. Pt complains of diplopia, occasional vertigo, tingling numbness in L LE, SOB when climbing stairs. Pt shows deficits in balance, cooking, laundry, driving, strength, and activity tolerance and coordination, runs into things stumbles upon things. Pt has pmhx of more than 4 falls last year, Cerebral infarction, Cerebrovascular disease, Diplopia, Essential hypertension, Hyperlipidemia, Other sequelae of cerebral infarction, Prediabetes, Multilevel degenerative changes at C4/5, C5/6 and C6/7 with cervical spinal stenosis, Cervical radiculopathy, Arnold-Chiari malformation status post brain surgery, Chronic constipation, Hypothyroidism, Hyperparathyroidism, Chronic vertigo, Hypomagnesemia. OT skilled intervention is required to improve L UE strength, coordination and activity independence.

OT GOALS

PATIENT-STATED GOAL: To improve strength on left side, fix meals and cook

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

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

	patient/caregiver recalls * lifestyle modifications to manage respiratory condition including * diet changes and regular exercise * strategies to control shortness of breath * home remedies to keep lungs healthy * recalls related medication(s) purpose, schedule patient/caregiver recalls * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain * teach relaxation skills and diversional activities * recalls related medication(s) purpose, schedule Sit to Stand - 06. Independent Car Transfer - 06. Independent 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 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

PT CAREPLAN
PT frequency WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26)

09/18/2026 Problems : 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, 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT NARRATIVE
Patient is an 88-year-old female with PMH significant for recent acute ischemic stroke s/p TNK thrombolysis, persistent left-sided weakness, diplopia, chronic vertigo/imbalance, cervical radiculopathy, cervical spinal stenosis, and HTN, referred for skilled HHPT evaluation following SNF rehabilitation. Patient presents with generalized and L-sided LE weakness (grossly 3+/5 to 4-/5), impaired dynamic balance, altered gait mechanics, and decreased activity tolerance, limiting safe bed mobility, transfers, and household ambulation. Patient previously ambulated with a cane due to vertigo/imbalance and currently requires an appropriate AD and caregiver assistance for safe mobility. Patient is homebound due to weakness, impaired balance, gait instability, and taxing effort required to leave the home. Skilled HHPT is indicated for progressive strengthening, balance training, gait/transfer training, fall prevention, and safe progression toward independent household mobility and discharge home with daughter. Medication regimen reviewed; education provided regarding medication adherence, fall prevention, pacing, and signs/symptoms requiring MD notification.

Patient is an 88-year-old female with PMH significant for recent acute ischemic stroke s/p TNK thrombolysis, persistent left-sided weakness, diplopia, chronic vertigo/imbalance, cervical radiculopathy, cervical spinal stenosis, and HTN, referred for skilled HHPT evaluation following SNF rehabilitation. Patient presents with generalized and L-sided LE weakness (grossly 3+/5 to 4-/5), impaired dynamic balance, altered gait mechanics, and decreased activity tolerance, limiting safe bed mobility, transfers, and household ambulation. Patient previously ambulated with a cane due to vertigo/imbalance and currently requires an appropriate AD and caregiver assistance for safe mobility. Skilled HHPT is indicated for progressive strengthening, balance training, gait/transfer training, fall prevention, and safe progression toward independent household mobility and discharge home with daughter. Medication regimen reviewed; education provided regarding medication adherence, fall prevention, pacing, and signs/symptoms requiring MD notification.

PT GOALS
PATIENT-STATED GOAL: Not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/11/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/02/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Yonas Tamrat**
1221 Mercantile Ln
Upper Marlboro, MD 20774
NPI 1528200409

Phone Number 8007777904

Fax Number

Physician's Signature and Date Signed

X

Yonas Tamrat , MD

09/02/2026: Date of physician last face-to-face