Department of Health and Human Services
Health Care Financing Administration

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
554-28-9666A	02/03/2000	From : 04/03/2000 To: 06/03/2000	13194	65-5421

6. Patient Name and Address
Smith, John (310) 384-8384
3344 Lincoln Blvd., #1234
Los Angeles CA 90292-

7. Provider's Name, Address and Telephone Number
All American Home Health Agency, Inc. (310) 785-7334
3434 Main St., #304
Marina del Rey CA 90292-

8. Date of Birth 10/18/1914 **9. Sex** [X] M [ ] F

11. ICD-9-CM	Principal Diagnosis	Date
298.0	REACT DEPRESS PSYCHOSIS	020200 (E)
12. ICD-9-CM	**Surgical Procedure**	**Date**
01.01	CISTERNAL PUNCTURE	
13. ICD-9-CM	**Other Pertinent Diagnosis**	**Date**
451.0	SUPERFIC PHLEBITIS-LEG	

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
(N) MEGACE SUSP. 600MG PO HS (N)
(N) PROZAC 10MG PO QAM
SEROQUEL 12.5 PO Q HS
THEO-DUR SA 200MG PO QAM
K-DUR 20MEG PO BID
THEO-DUR SA 100MG PO Q HS
CYPROHEPTAD 4MG PO Q HS
ARICEPT 10MG PO Q HS
TEMAZEPAM 15MG PO Q HS PRN

14. DME and Supplies
BETADINE WIPES, COTTON TIP APPLICATOR

15. Safety Measures: Cont. on 487
EMERGENCY, FIRE RESPONSE AND DISASTER PI

16. Nutritional Req.
LOW CHOLESTEROL, LOW FAT

17. Allergies:
PENICILLIN

18.A. Functional Limitations
1. [ ] Amputation
2. [ ] Bowel/Bladder (Incontinence)
3. [ ] Contracture
4. [ ] Hearing
5. [ ] Paralysis
6. [X] Endurance
7. [X] Ambulation
8. [ ] Speech
9. [ ] Legally Blind
A. [ ] Dyspnea w/mi
B. [X] Other(Specify)

UNSTABLE MENTAL STATUS

18.B. Activities Permitted
1. [ ] Complete Bedrest
2. [ ] Bedrest BRP
3. [X] Up As Tolerated
4. [ ] Transfer Bed/Chair
5. [ ] Exercise Prescribed
6. [ ] Partial Weight Bearing
7. [ ] Indpendent At Home
8. [ ] Crutches
9. [ ] Cane
A. [ ] Wheelchair
B. [ ] Walker
C. [ ] No Restrictions
D. [X] Other (Specify)

CZEODEWARDENPANTONSNOWBACH

19. Mental Status
1. [X] Oriented
2. [ ] Comatose
3. [X] Forgetful
4. [X] Depressed
5. [ ] Disoriented
6. [ ] Lethargic
7. [X] Agitated
8. [ ] Other

20. Prognosis : 1. [ ] Poor 2. [ ] Guarded 3. [X] Fair 4. [ ] Good 5. [ ] Excellent

21. Orders for Discipline and Treatments (Specify amount/Frequency/Duration) Cont. on 487

SN 3 WK 3 - SN FOR SKILLED OBSERVATION AND ASSESSMENT OF PSYCH STATUS/NUTRITION STATUS, WEIGHT Q WK.
SN TO ASSESS SLEEP PATTERN, BEHAVIOR, ASSESS RESPIRATORY TO MED CHANGES, MENTAL STATUS, VS, ADL'S, FOR SAFETY HAZARDS IN HOME, LUNG SOUNDS, APPETITE, NUTRITION & HYDRATION, BLADDER/BOWEL FUNCTION & SOUNDS, S/S DISEASE PROCESS AND REPORT COMPLICATIONS TO PHYSICIAN.SN CONCERNED WITH PATIENT SKIPPING MEALS, REFUSING TO ATTEND MEALS AND SOCIAL ISOLATION.

INSTRUCT AS NEEDED.

AIDE - 3 WK 2 - TUB/SHOWER BATH, PERSONAL CARE, ASSIST WITH AMBULATION, HOUSEKEEPING (LIMITED), SN TO SUPERVISE HHA EVERY 2 WEEKS.

62 - DAY SUMMARY: PATIENT TO BE RECERTED FOR PSYCH SN INTERVENTION SHORT TERM. PATIENT AFFECT FLAT, INCREASINGLY WITHDRAWN, VERY DEPRESSED, SKIPPING MEALS, REFUSING MEALS AND EXPRESSING NO INTEREST IN FOOD;HAS LOST 18 LBS. SINCE SOC AND MEGACE ORDERED TO

22. Goals/Rehabilitation Potential/Discharge Plans Cont. on 487

SN GOALS: PATIENT WILL DEMONSTRATE INCREASED SOCIAL INTERACTION BY 04/21/00. PATIENT'S WEIGHT WILL STABILIZE WITHIN 3 WKS.
AIDE GOALS - MAINTAIN GOOD PERSONAL HYGIENE AND SKIN INTEGRITY IN 5 WEEKS.
SN PROGNOSIS - FAIR: PARTIAL RECOVERY IS EXPECTED.
SN D/C PLANS - PT WILL BE DISCHARGED TO MY CARE WHEN CONDITION IS STABILIZED AND

23. Nurse's Signature and Date of Verbal SOC where Applicable:

25. Date HHA Received Signed POT

24. Physician's Name and Address
Johnson, Magic (310) 983-9933
9987 Santa Monica Blvd., #989
Santa Monica
CA 90292-
UPIN A93949

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.

27. Attending Physician's Signature and Date Signed

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.

Signature applies to attached 487(s)