CLAIM AND ITEMIZED STATEMENT OF RELIEF SOUGHT

Pursuant to Section 893.80(1)(a)

CITY OF MILWAUKEE
12 JAN 11 PM 2:30
RONALD D. LEONHARDT
CITY CLERK

TO: City of Milwaukee
200 East Wells Street
Milwaukee, Wisconsin 53202

Pursuant to law the claimant, Mary Ann Brannon, hereby files this claim against the above named municipality through her attorneys the law firm of Weigel, Carlson, Blau & Clemens, S.C.

1. Name and address of the claimant are:

Mary Ann Brannon
9219 West Adler Street
West Allis, Wisconsin 53214

2. For statement of relief sought is a demand for damages as a result of the accident described as follows:

   A. That Mary Ann Brannon is an adult residing at 9219 West Adler Street, West Allis, Wisconsin 53214.

   B. That on or about the 2nd day of June, 2010, at approximately 12:00 p.m., Ms. Brannon suffered injuries while walking on the sidewalk directly in front of the Marcia P. Coggs Human Services Center located at 1220 West Vliet Street, Milwaukee, Wisconsin, when she tripped on the in-ground planter that is on the sidewalk and fell, causing injuries to her.

   C. That as a direct and proximate result of the ~~County~~ City (GEC) of Milwaukee's negligence in said planter's poor design and/or maintenance which caused said planter to not be level with the sidewalk.

   D. That as a direct and proximate result of the ~~County~~ City (GEC) of Milwaukee's negligence, Ms. Brannon was caused to suffer personal injuries including, but not limited to, a broken right fibula, broken right ankle and sprained left ankle, as well as other injuries.

   E. That on July 30, 2010, a Written Notice of Circumstances of Claim Pursuant to Section 893.80(1)(a) was served upon the City of Milwaukee and a copy thereof is attached hereto.

3. An itemization of the claim is as follows:

Bell Ambulance	6-2-10	$715.86
Internal Medicine Assoc.	6-2-10 to 6-3-10 & 10-20-10	$892.57
Milwaukee Anesthesia Consultants	6-3-10	$207.65
West Allis Memorial Hospital	6-2-10 to 6-4-10	$25,248.25
Aurora Medical Group	6-2-10	$100.00
ERMED, S.C.	6-2-10	$912.00
Aurora Visiting Nurse	6-4-10 to 11-9-10	$256.60
Gentiva Health Services	6-5-10 to 9-16-10	$16,641.00
Diagnostic Mobile Imaging, LLC	8-3-10	$258.00

2012 JAN 12 PM 2:50
CITY OF MILWAUKEE
RECEIVED

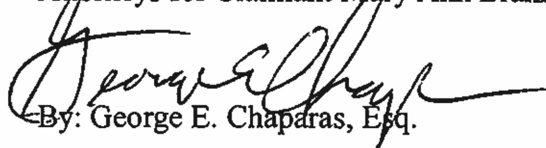
Total Medical Bills: $45,231.93

Plus Pain and Suffering of $4,768.07

TOTAL CLAIM: $50,000.00

Dated at Milwaukee, Wisconsin this 16 day of December, 2011

WEIGEL, CARLSON,
BLAU & CLEMENS, S.C.
Attorneys for Claimant Mary Ann Brannon



By: George E. Chaparas, Esq.

GEC/kr

PLEASE RETURN THIS STUB WITH YOUR PAYMENT

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

549 E WILSON ST
MILWAUKEE, WI,
53207-1635

#BWNDSFD
#26 10 0153 0041 0 4#

MARY A BRANNON
2092 S 102ND ST
109
MILWAUKEE, WI 53227-1317

Client Name: **BRANNON, MARY A**

Trip Number:

10-1530041

Service Date: **06/02/2010**

Amount Due: $ 0.00

Billing Date: **10/04/2011**

Billing Department: (414) 486-2000
Toll-Free Number: (800) 896-6200
Se Habla Español: (414) 486-4016

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

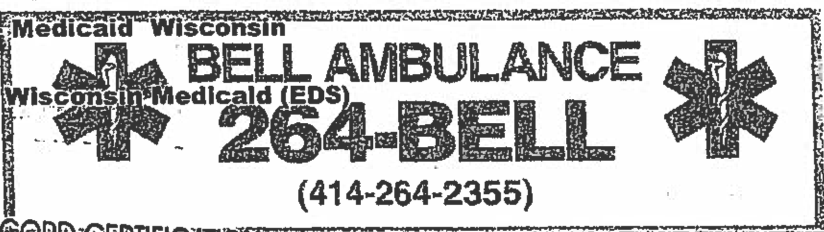
Billing Department: (414) 486-2000
Toll-Free: (800) 896-6200
549 E WILSON ST
MILWAUKEE, WI, 53207-1635

Service Date: **06/02/2010**
Trip Number: **10-1530041**
Client Name: **BRANNON, MARY A**
Caller:
From Location: **N 12TH ST & W VLIET ST**
To Location: **WEST ALLIS MEMORIAL**

Insurance Information

WPS Medicare Part B **Patient SSN A**

DATE	DESCRIPTION OF TRANSACTION	HCPC	QUANTITY	UNIT PRICE	AMOUNT
06/02/10	BLS Emergency Base Rate	A0429	1	$510.00	$510.00
06/02/10	Mileage	A0425	10	$14.00	$140.00
06/02/10	Ice Pack - BLS - F	A0382	1	$3.52	$3.52
06/02/10	Misc. Services	A0382	1	$62.34	$62.34
06/22/10	Manual Contractual - Medicare WPS Medicare Part B				$331.57
06/22/10	Payment - Medicare WPS Medicare Part B				$53.92
06/22/10	Payment - Medicare WPS Medicare Part B				$253.51
10/20/10	Manual Contractual - Medicaid Wisconsin Medicaid (EDS)				$75.18
10/20/10	Payment - Medicaid Wisconsin Medicaid (EDS)				$1.68



"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

PLEASE PAY THIS AMOUNT => $0.0

RECORD CERTIFICATION
As custodian of records at Bell Ambulance Service, I hereby certify that this and any documents annexed hereto, consisting of 8 pages, are accurate, legible and complete duplicates of medical records or bills for the named client on the dates shown.

Date 10/4/11 Signature [signature]

IRS NUMBER 39-1307909

FINAL

Patient Care Report

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"

BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

CREW INFO

Vehicle : 433

Crew #1:

Crew #2:

Doc'd By:

Assisted By: 0
0
0

RESPONSE INFO

Med/Trauma: Medical and Trauma

Response Priority: CODE-3 (10-17)

Nature Of Call: LEG / FOOT PAIN

Start Mileage:

Response Mileage: 0.0

Resp. Delay: <None>
<None>
<None>

Trans. Delay: <None>
<None>
<None>

Call Taken by: MILWAUKEE FIRE DEPT

Resp. with:

Location: N 12TH ST & W VLIET ST
MILWAUKEE, WI 53205

Locn Type: Public Outdoors

Pt. Found: Other (See Narrative)

DISPOSITION

Outcome: Treated/Transported FAX REPORT NEEDED

Dest. Reason: Closest Facility

Transport Priority: CODE-2 (10-16)

At Scene Mileage: 1.9

At Dest. Mileage: 11.6

Condition at Dest.: Unchanged

Level of care:

Barriers to Care: None
None
None

Pt. Transported: Supine/Head Elevated - Stretcher

Destination: WEST ALLIS MEMORIAL HOSPITAL
Dept: EMERGENCY DEPT
8901 W LINCOLN AVE
WEST ALLIS, WI 53227-2409

Transport Reason : Col Needed

Transport Reason : Emergency Situation

Service Not Available :

Transport Explanation : rt ankle pain

TIMES

Recvd: 10:39 06-02-10

Dispatch: 10:40 06-02-10

En route: 10:40 06-02-10

At scene: 10:45 06-02-10

At patient: 10:48 06-02-10

Transport: 11:09 06-02-10

At dest.: 11:26 06-02-10

In service: 11:58 06-02-10

At base: 11:58 06-02-10

PATIENT INFORMATION

Name : mary ann brannon

Phone : (414) 731-1563

DL Info :

SSN : 394-58-4069

DOB : 09/29/1951 (60 yrs)

Weight : 200 lbs

Sex : Female

Home Addr. : 2092 S 102 109
MILWAUKEE, WI 53227

Mailing Addr. :

Race : White

NEXT OF KIN

Name : fred brannon

Phone : (414) 731-1561

SSN :

DOB :

Sex :

Home Addr. :

INSURANCE

Work Related: No

Provider Info:

Company: WPS Medicare Part B

Policy #: 394-58-4069

Group #:

FINAL

Patient Care Report

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BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

Employer Information

Employer:

Employer Phone:

Employer Address:

Employer City:

Employer State:

Employer Zip:

HISTORY

Allergies

Other - Not Listed

Note: ceflex

Latex

Aspirin (ASA)

Cause of Injury

Falls

Note: standing fall

Chief Complaint

Fall Victim

Medications

Albuterol -

Singulair -

Past Medical History

Other

Note: asthma

FINAL

Patient Care Report

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BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

ASSESSMENTS

06/02/2010 11:06:00 By:

Body Area	Assessment	Body Area	Assessment
Airway	Patent Patent :	Breathing	Normal Respirations Normal Respirations :
Circulation	Pulses - Radial - Normal (2+) Pulses - Radial - Normal (2+) :	Central Nervous System	Neuro Intact Neuro Intact :
Head	Assessed with No Abnormalities Assessed with No Abnormalities :	Face	Assessed with No Abnormalities Assessed with No Abnormalities :
Right Ear	Assessed with No Abnormalities Assessed with No Abnormalities :	Left Ear	Assessed with No Abnormalities Assessed with No Abnormalities :
Right Eye	Pain Pain :	Left Eye	Assessed with No Abnormalities Assessed with No Abnormalities :
Nose	Assessed with No Abnormalities Assessed with No Abnormalities :	Neck	Assessed with No Abnormalities Assessed with No Abnormalities :
Trachea	Midline Midline :	Chest	Assessed with No Abnormalities Assessed with No Abnormalities :
Pelvis	Assessed with No Abnormalities Assessed with No Abnormalities :	Genitalia	Not Assessed Not Assessed :
Upper Right Arm	Assessed with No Abnormalities Assessed with No Abnormalities :	Upper Left Arm	Assessed with No Abnormalities Assessed with No Abnormalities :
Lower Right Arm	Assessed with No Abnormalities Assessed with No Abnormalities :	Lower Left Arm	Assessed with No Abnormalities Assessed with No Abnormalities :
Right Hand	Assessed with No Abnormalities Assessed with No Abnormalities :	Left Hand	Assessed with No Abnormalities Assessed with No Abnormalities :
Upper Right Leg	Assessed with No Abnormalities Assessed with No Abnormalities :	Upper Left Leg	Assessed with No Abnormalities Assessed with No Abnormalities :
Lower Right Leg	Assessed with No Abnormalities Assessed with No Abnormalities :	Lower Left Leg	Assessed with No Abnormalities Assessed with No Abnormalities :
Right Foot	Assessed with No Abnormalities Assessed with No Abnormalities :	Left Foot	Assessed with No Abnormalities Assessed with No Abnormalities :
Alcohol/Drugs	Patient Denies Alcohol/Drug Use Patient Denies Alcohol/Drug Use :	Back - Lower	Assessed with No Abnormalities Assessed with No Abnormalities :
Back - Upper	Assessed with No Abnormalities Assessed with No Abnormalities :	Level of Consciousness	A & O x 4 A & O x 4 :

FINAL

Patient Care Report

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BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

Lower Left Quadrant	Assessed with No Abnormalities Assessed with No Abnormalities :	Lower Right Quadrant	Assessed with No Abnormalities Assessed with No Abnormalities :
Mental Status	Normal (A & O x 4) Normal (A & O x 4) :	Throat/Mouth	Assessed with No Abnormalities Assessed with No Abnormalities :
Upper Left Quadrant	Assessed with No Abnormalities Assessed with No Abnormalities :	Upper Right Quadrant	Assessed with No Abnormalities Assessed with No Abnormalities :

IMPRESSIONS

Primary Impression: Pain/Other General Symptoms

TRAUMA

Trauma Description

Fall of 1-6 Feet

VITAL SIGNS

Time	BP	Pulse	Respiratory	SPO2	EtCO2	Glucose	GCS
11:08	158/80 Auscultated	88, Strong, Regular	18 Normal, Regular				E4 + V5 + M6 = 15

Skin Temp=Normal Skin Color=Normal Skin Moisure=Normal Lung Sounds Left=Normal / Clear Lung Sounds Right=Normal / Clear
Pupil size: Left=3mm, Right=3mm Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Pain Scale=10; Arm Movement: Left=Spontaneous, Right=Spontaneous; Leg Movement: Left=Spontaneous, Right=Spontaneous

Completed By:

TRAUMA SCORES

no trauma scores entered

Comments:

TREATMENT SUMMARY

Time	PTA	Treatment	Who performed	Comments
11:06		PATIENT CONTACT MADE		

Complication — Complication Narrative

GLOVES PER PAIR=04

Time	PTA	Treatment	Who performed	Comments
11:06		SECURED TO COT		

Complication — Complication Narrative

HOW SECURED=siderails up, seatbelts x 5 FITTED SHEET QTY=01 FLAT SHEET QTY=01

PILLOW CASE=01

FINAL

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BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

TREATMENT SUMMARY CONTINUED

Time	PTA	Treatment	Who performed	Comments
11:20		COLD PACK		

Complication — Complication Narrative

Indication=Swelling Control — Result=None — Location=rt and left ankle

Quantity=02 — Performed PTA By=Not Applicable

Time	PTA	Treatment	Who performed	Comments
11:22		Miscellaneous Supplies		

Complication — Complication Narrative

Ice Pack=02

Time	PTA	Treatment	Who performed	Comments
11:23		SPLINTING		

Complication — Complication Narrative

INDICATION=Possible Fracture — EXTREMITY=Right Foot/Ankle — CMS BEFORE=Present

TYPE=Pro-Splint — SPLINT QTY=01 — RESULT=Immobilization without CMS Change

PERFORMED PTA BY=Not Applicable

Time	PTA	Treatment	Who performed	Comments
11:24		Immobilization Supplies		

Complication — Complication Narrative

Pro Splint Leg - Adult=01

NARRATIVE

Upon arrival found a 58 y/o female sitting on the ground outside a public building. Pt complaining of rt ankle pn from a standing fall. Pt was, "pushed from behind and twisted it on a depression near the sidewalk." Pt denies any other pain. Pain does not radiate and it rated 10/10. Pain is contant but worse with movement Pt had full cms prior to and after applying a proslint to her ankle. Ankle was swollen, an ice pack was applied. Pt transferred and secured to cot times 5. Pt vitals taken, w/in normal. Along the way the pt left ankle began to swell. A second ice pack was applied to the left ankle. Pt transported to west allis hospital woi. Pt care transferred to facility care member.

FINAL

Patient Care Report

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BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

SIGNATURES

Time	Type	Who signed	Why patient did not sign
06/02/2010 11:25	(1) Assignment & Guarantee / HIPAA	Self - brannon, mary ann	N/A

ASSIGNMENT & GUARANTEE / HIPAA

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Bell Ambulance, Inc. for any ambulance services and supplies furnished to me by Bell Ambulance, Inc., whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payors and their respective agents and contractors, as well as Bell Ambulance, Inc. any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future. This authorization is in effect until I choose to revoke it.

I hereby agree to pay charges for services provided to me by Bell Ambulance, Inc. in accordance with Bell Ambulance, Inc.'s regular rates and terms. I understand that each bill is due and payable within 10 days, and 1% per month late payment penalty will apply to any amount not paid when due. Should my account be referred to an attorney for collection, I agree to pay reasonable attorneys' fees and collection expenses.

I hereby acknowledge that I have been provided with a copy of the Bell Ambulance, Inc. Notice of Privacy Practices on this date.

I certify that I have read the foregoing, understand it, and accept its terms.

X mary A Brannon

Time	Type	Who signed	Why patient did not sign
06/02/2010 11:39	Report Given To	Facility Staff Member - b, jana	N/A

I have recieved report for mary ann brannon from CONDON, BRIGID, ANTON, KEN and accept this patient.

X [illegible]

FINAL

Patient Care Report

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

BELL AMBULANCE INC

549 E WILSON ST
MILWAUKEE, WI 53207-1635
(414) 486-2000 Ext.

Run Number: 1530041

Date of Service: 06/02/2010

Patient Name: mary ann brannon

CREW INFORMATION

Start Date/Time: 06/02/2010 10:00

Crew #	Name	Crew #	Name
3465		3386	

x [signature] x [signature]

CHANGE TRACKING

Caption	Date/Time	Change	Who Changed

Aurora Health Care®

CERTIFICATION OF MEDICAL RECORDS

Patient Name: Mary Ann Brannan DOB 9/29/1951

I certify that the documents attached to this certificate, consisting of 248 pages, are accurate, legible, and complete duplicates of the original medical records of the patient listed above for the following time period:

6/2/2010 to 1/13/2011

Exclusions:
[X] None
[ ] As follows:

I further certify that the original records were: (1) made at or near the time of the occurrence of the matters set forth by, or information transmitted by, a person with knowledge of those matters; (2) kept in the course of the regularly conducted activity; and (3) made by the regularly conducted activity as a regular practice.

I certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 17 day of January 2011.

Rhonda Niehaus, RHIA
Rhonda Niehaus, RHIA

Aurora West Allis Medical Center
8901 W Lincoln Ave.
West Allis, WI 53227

WAMH

MRN 6-4-10

LATEX ALLERGY

MRU: WMH-00275564
FIN NUM: WMH-08000657116
ADM DATE: 06/02/2010 17:31
CPI: WMH-000275564
LOC/UNIT: 3P2-WAMH
ROOM: 306
BED: 01
SERVICE: Medical
ADM TYPE: Emergency
ADDL LOC:

PT PREFERRED NAME

BRANNON, MARYANN
APT 109
2092 S 102ND ST
WEST ALLIS, WI 53227
H: (414) 731-1563
A:
MAIDEN NAME
APKARIAN
BIOREP

DOB 09/29/1951
AGE 58 Y
GENDER Female
PT EMPLOYER None
LANGUAGE English
INTERP
MARITAL STATUS Married
RELIGION Catholic
CLERGY VISIT NONE
CHURCH None

Status: Not Employed
Occ: DISABILITY
Ret Date:
ENC TYPE: Inpatient

GUARANTOR
BRANNON, MARYANN
APT 109
2092 S 102ND ST
WEST ALLIS, WI 53227
H: (414) 731-1563

PT REL TO GUA Self
A:

DOB 09/29/1951
GENDER Female

GUARANTOR EMPLOYER None

Status: Not Employed
Occ: DISABILITY
Ret Date:

PRI INSURANCE 317	**SEC INSURANCE**	**3RD INSURANCE**
*Medicare Part A NGS PO Box 7149 Indianapolis, IN 46207		
POL#: 394584069A	POL#:	POL#:
GRP#:	GRP#:	GRP#:
GRP NAME:	GRP NAME:	GRP NAME:
SUBSCRIBER	**SUBSCRIBER**	**SUBSCRIBER**
DOB 09/29/1951 BRANNON, MARYANN	**DOB**	**DOB**
PT REL TO SUB Self	**PT REL TO SUB**	**PT REL TO SUB**
NETWORK	**NETWORK**	**NETWORK**

PHYSICIANS
Admit: Munim, Shahida R
Attending: Munim, Shahida R
Procedure:

Family: Munim, Shahida R
Referring: None, None
Resident:

FIN

COMPLAINT: BILAT TRIMALLEOLAR FX

ACCIDENT
Other Accident
OTHER ALLERGIES

ACC DATE
06/02/2010

*** VERIFY THAT THIS IS THE MOST CURRENT CONTACT INFO *

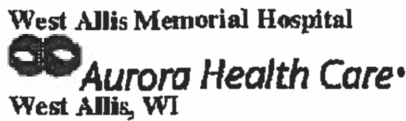
1ST CONTACT PERSON	**2ND CONTACT PERSON**
BRANNON, FRED M	BAILEY, ROBERTA M
(414) 779-9945	(414) 758-3235
PT REL TO CONTACT	**PT REL TO CONTACT**
Wife	Mother

COMMENTS:
UPD TG/ICC 3/17/10/COPAY $40 DENIED ER MD SMITH

Pre-Admit By:
Admit By:
Last Updated By: KA
Print Date: 06/02/10 17:39

Facesheet

FACESHEET - PERMANENT PATIENT RECORD

West Allis Memorial Hospital


West Allis, WI

MRN: WMH-00275564
Patient Name: BRANNON, MARYANN
DOB: 09/29/1951
Case #: WMH-08000657116
Admit Date: 06/02/2010
Discharge Date: 06/04/2010
Pt. Loc/Type/Room: 3P2-WAMH Inpatient 306

SPECIALTY CODE: 953

CONSULTING PHYSICIAN: Sean E Wilson/ESA, DPM

DATE OF ADMISSION: 06/02/2010
DATE OF CONSULTATION: 06/02/2010

REFERRING PHYSICIAN:
Emergency department.

CHIEF COMPLAINT:
Right ankle fracture, left ankle sprain.

HISTORY OF PRESENT ILLNESS:
The patient is a 58-year-old female who reports being down at the county building this morning. She said there was a lot of commotion and an argument between 2 parties unknown to the patient, and she was pushed, and fell, rolled over 1 ankle, and then fell and broke the other ankle. The patient is currently experiencing 10/10 pain on the right and mild pain on the left. The patient is able to bear some weight on the left side. She presented to the West Allis emergency room where she is seen at the present time. No other complaints.

ALLERGIES:
Aspirin.
Cyclobenzaprine.
Codeine.
Darvocet.
Keflex.
Latex.
Nubain.

PAST MEDICAL HISTORY:
Hemorrhoids.
Chronic obstructive pulmonary disease.
Hypertension.
Cholecystectomy.
Asthma.

SOCIAL HISTORY:
The patient smokes a pack and a half of cigarettes a day. Denies alcohol or illicit drug use. She is unemployed and married, lives with her husband. Has an elevator in the building.

PAST SURGICAL HISTORY:

The patient reportedly has had multiple surgeries on both ankles for previous fractures.

FAMILY HISTORY:
Noncontributory.

REVIEW OF SYSTEMS:
Negative other than what is noted in the history of present illness.

MEDICATIONS:
Percocet.
Flexeril.
Albuterol.
Advair Diskus.
Singulair.
Multivitamin.
Senna.
Sea Mist Nasal Spray.
Currently receiving Morphine.

PHYSICAL EXAMINATION:
GENERAL: The patient is awake, alert and oriented to person, place and thing.
VITAL SIGNS: Reviewed per chart.
HEENT: Normocephalic and atraumatic. Pupils are equally round, reactive to light and accommodation. Extraocular movements are intact.
CARDIOVASCULAR: Regular rate and rhythm.
LUNGS: Clear to auscultation bilaterally.
ABDOMEN: Nontender, nondistended. Normal bowel sounds.
EXTREMITIES: Lower extremities integument: The skin is intact bilaterally with no lesions. There is no ecchymosis noted at this time.
Vascular: Dorsalis pedis, posterior pulses are palpable bilaterally. Capillary fill time is instantaneous to the toes bilaterally. There is noted edema to bilateral ankles. There is no noted erythema.
NEUROLOGIC: Intact to light touch of the digits bilaterally.
MUSCULOSKELETAL: There is pain on palpation and range of motion of the right ankle. There is some mild pain on palpation of the left ankle. No gross deformity is noted.

DIAGNOSTIC DATA:
X-rays reveal a fracture of the right fibula and a posterior malleolar fracture with medial gutter widening of the right ankle. Left ankle: No fracture is noted.

Cultures: Not applicable.

LABORATORY DATA:

Hemoglobin 16.0, hematocrit 47.0, white blood cells 11.2, platelets 184. Sodium 139, potassium 4.0, chloride 106, carbon dioxide 25, BUN 12, creatinine 0.9, glucose 97, INR 1.0.

ASSESSMENT:
1. Right ankle fracture.
2. Left ankle sprain.

PLAN:
1. The patient was evaluated and consult dictated.
2. Will schedule open reduction internal fixation on 06/03/2010 at 10:45 a.m.
3. N.p.o. after midnight tonight.
4. Nonweightbearing to the right, weightbearing as tolerated on the left with a Cam walker.
5. Dispense a Cam boot for the left.
6. Physical therapy and occupational therapy to evaluate for crutches, walker or a wheelchair.
7. EKG, chest x-ray.
8. Hospitalist for surgical history and physical.
9. Medical management per hospitalist.
10. Will follow.
11. Page for questions, 558-1488.

This consult was performed in a teaching fashion with Dr. Sean Wilson.

Electronically Authenticated
Sean E Wilson/ESA, DPM 06/03/2010 10:56
Signing Provider
Sean E Wilson/ESA, DPM

Dictating Provider
Michael Corcoran/ESA, DPM

MC/SMF (004091168)
d. 06/02/2010 5:06 P
t. 06/02/2010 7:45 P
Document #: 1184498

copies: Michael Corcoran/ESA, DPM
Shahida Munim/ESA, MD
Sean E Wilson/ESA, DPM

Emergency

History and Physicals

WEST ALLIS MEMORIAL HOSPITAL

ADMISSION DATE: 06/02/2010

HISTORY OF PRESENT ILLNESS:
She is a 58-year-old female with past medical history of bronchial asthma. The patient came to the emergency room after a fall. According to patient, she was in her usual state of health. While she was in the county building, she was pushed and after that she fell down and twisted her ankle with severe pain. Subsequently, the patient came to the emergency room. The patient is admitted for further evaluation and treatment. The patient denies any shortness of breath. Denies any palpitation. Denies any chest pain, denies any bleeding from any part of the body.

PAST MEDICAL HISTORY:
Significant for bronchial asthma and hypertension. The patient also has a surgical history of cholecystectomy.

ALLERGIES:
Codeine, Nubain, Aspirin, Keflex and Darvon.

SOCIAL HISTORY:
Significant for smokes about 1 pack a day.

MEDICATIONS:
1. Advair Diskus 250/50 one puff b.i.d.
2. Albuterol 1 puff every 6 hours as needed.
3. Flexeril 10 mg p.o. q.6h. p.r.n.

4. Singulair 5 mg p.o. daily.

LABORATORY DATA:
Sodium is 139, potassium 4.0, chloride 106. Glucose 97. WBC 11.2, hemoglobin 15.5, hematocrit 46.2. INR 1.0. Urinalysis is negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 133/82, pulse 86, temperature is 98.
HEENT: PERRLA. Throat clear, no exudate.
NECK: Supple. There is no adenopathy. There is no JVD.
CHEST: Nontender, moving equally on both sides. There are no wheezes, no crackles.
CARDIOVASCULAR: Normal S1 and S2. No S3, S4.
ABDOMEN: Soft and nontender. No hepatosplenomegaly. Bowel sounds positive.
EXTREMITIES: Shows tenderness, positive in both ankles, no deformity. Edema is positive in both ankles.

IMPRESSION:
1. Right ankle fracture and the left ankle sprain.
2. Bronchial asthma.
3. Hypertension.

PLAN:
Admit the patient on the floor. Order for the EKG and chest x-ray. Pain control with Morphine. Continue home medications and possible surgery tomorrow.

Electronically Authenticated
Masroor Munim/ESA, MD 06/11/2010 16:27

Dictating Provider
Masroor Munim/ESA, MD

MM/MMD (004091294)
d. 06/02/2010 5:20 P
t. 06/02/2010 7:47 P
Document #: 1184499

copies: Masroor Munim/ESA, MD
Shahida Munim/ESA, MD

(Update is required at time of admission for any History and Physical

done prior to patient arrival at the hospital. This section may also be used at the end of the stay as an update for patient transfer to another facility.)

Addendum to this history and physical:
__ No change OR __ Additions as stated here:

____

____
Physician's Signature Date

Hosp Dischg Summ

WEST ALLIS MEMORIAL HOSPITAL

ADMISSION DATE: 06/02/2010 DISCHARGE DATE: 06/04/2010

DIAGNOSIS:
Right ankle fracture.

REASON FOR HOSPITALIZATION:
Pain control and open reduction internal fixation right ankle fracture.

HOSPITAL COURSE:
The patient was admitted to West Allis Memorial on the afternoon of 06/02/2010. The patient was started on Vicodin 5/500 q.4-6h. for pain. The patient underwent open reduction internal fixation of the right ankle on 06/03/2010 by Dr. Sean Wilson. The patient tolerated the procedure and anesthesia well. The patient was then started on Dilaudid PCA for pain control. The patient was discharged the following day, 06/04/2010, on Percocet 5/325, OxyContin 20 mg q.12h. and Coumadin 2 mg tablets 2 pills p.o. daily.

PERTINENT DIAGNOSTICS:
X-rays showing fracture of the right ankle.

IMPRESSION:
Status post open reduction and internal fixation right ankle fracture.
The patient is doing well.

DISCHARGE PLAN:
The patient is to be non-weight bearing to the right foot and ankle with use of crutches or walker for PT. The patient is to follow up with Dr. Sean Wilson in approximately 1 week.

DISCHARGE MEDICATIONS:
1. Percocet 5/325.
2. OxyContin 20 mg.
3. Coumadin 2 mg 2 tablets daily.

Gentiva Home Health has set up outpatient laboratory draws to monitor INR.

CONDITION ON DISCHARGE:
Stable and good.

Primary care physician, Dr. Munim performed pre-surgical H and P.

This patient was seen under the teaching service of Dr. Sean Wilson, who was available for any questions or concerns for the patient and the family.

Electronically Authenticated
Sean E Wilson/ESA, DPM 06/24/2010 12:32
Signing Provider
Sean E Wilson/ESA, DPM

Dictating Provider
Michael Corcoran/ESA, DPM

MC/HB (004111465)
d. 06/08/2010 1:38 P
t. 06/11/2010 12:54 P
Document #: 1187624

copies: Michael Corcoran/ESA, DPM
Shahida Munim/ESA, MD
Sean E Wilson/ESA, DPM

WEST ALLIS MEMORIAL HOSPITAL

ADMISSION DATE: 06/02/2010 DISCHARGE DATE: 06/04/2010

REASON FOR ADMISSION:
Right ankle fracture and left ankle sprain. For more details on History of Present Illness, Past Medical History, Family and Social History, and Admission home meds, please refer to the dictated H& P from 06/02/2010.

HOSPITAL COURSE:
Patient was admitted to the orthopedic floor via emergency room. Seen in consultation by podiatry, Dr. Sean Wilson. Her x-rays done on admission revealed distal right fibular metaphysis fracture and posterior malleolar fracture. Left ankle: No evidence for fracture, subluxation or dislocation except for small calcaneal spur. Since patient was in excruciating pain, she was subsequently taken to the operating room on 06/03/2010 for open reduction internal fixation of right ankle.

Her postoperative course was uncomplicated except for some pain issues which was predictable. Her pain was controlled appropriately initially with PCA, later on switched to oral narcotic pain medications. The patient underwent PT, OT evaluation for nonweightbearing training of right foot today, which is 06/04/2010. Hence being discharged home in a stable condition. Her husband is on her bedside. The husband went through OT, PT orientation along with her and both patient and her husband feel that they would be able to handle her at home. We are also setting her up with home OT, PT. Also, since patient has been started on Coumadin, she will have home draws twice a week for her INR check.

DISCHARGE MEDICATIONS: These are her home medications which are:
1. Montelukast (Singulair) 5 mg daily.
2. Multivitamin 1 tablet daily.
3. Senna 8.5 mg 3 times daily.
4. Sodium Chloride nasal sea mist nasal spray as needed.
5. Nicotine patch 14 mg daily for 2 weeks. After that, would be on Nicotine patch 7 mg per day for 2 weeks and then she can discontinue it. Patient is aware that she cannot wear the patch and smoke at the same time and she has decided to quit smoking. Hopefully, she will stick to her decision.
6. Omeprazole 40 mg daily for GERD.

Pain medications that she is being discharged home on are:
1. Percocet 5/325 mg 1 to 2 tablets every 4-6 hours as needed for pain.
2. OxyContin 10 mg daily, 1 tablet every 12 hours for pain.
3. Coumadin 2 mg 2 tablets daily.

ASSESSMENT AND PLAN:
A 58-year-old female status post open reduction and internal fixation of right ankle fracture being discharged home with blood thinning medicines and narcotic pain medicines, as well as nicotine patch. The patient is to have home OT, PT. Would also get home lab draws for her INR to be monitored closely while she is physically not active or ambulating. She is to be followed up as an outpatient in my office once she becomes ambulatory or if she has any other problems. Also, to be followed up by Dr. Sean Wilson as scheduled.

Electronically Authenticated
Shahida Munim/ESA, MD 06/30/2010 16:28

Dictating Provider
Shahida Munim/ESA, MD

SM/DML (004099341)
d. 06/04/2010 2:49 P
t. 06/08/2010 2:02 P
Document #: 1185944

copies: Shahida Munim/ESA, MD

Operative and Procedure

WEST ALLIS MEMORIAL HOSPITAL

DATE: 06/03/2010

PREOPERATIVE DIAGNOSIS:
Bimalleolar ankle fracture, right.

POSTOPERATIVE DIAGNOSIS:
Bimalleolar ankle fracture, right.

PROCEDURE:
1. Open reduction internal fixation of right bimalleolar ankle fracture.
2. Open repair of right deltoid ligament.

SURGEON:
Sean E Wilson DPM

RESIDENT:
Michael Corcoran DPM

ANESTHESIA:
General.

INDICATIONS:
The patient presented to the emergency room with an acutely fractured and displaced right ankle fracture. This fracture was reduced in the emergency room. The patient was splinted. Discussion was had with the patient regarding the need for surgical intervention for stabilization of the fracture. The patient understands all risks and benefits and expected outcomes of the procedure. Radiographic and clinical evidence correlates well with the above diagnoses.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room via gurney and placed on the operating table in supine position. After induction of general anesthesia, the mid ankle was anesthetized with 30 cc of 0.5% Ropivacaine injected proximal at the surgical site. The foot was then prepped and draped in the usual aseptic manner. Previously applied thigh tourniquet was then inflated on the right side to 300 mmHg.

Attention was directed to the right lateral aspect of the right ankle where the fracture was palpated in an 8 cm linear incision was placed directly overlying the fracture. The incision was deepened through subcutaneous tissue with care taken to identify and retract vital neurovascular structures. Periosteal tissues were reflected away from the fracture and the fracture exposing the operative field. A hematoma was gently debrided from the fracture site. Next, the fracture was reduced and temporarily held in place using a reduction forceps. Next, according to standard operating technique, a Synthes 3.5 mm cortical screw was driven across the fracture in a perpendicular orientation with excellent compression being noted. The reduction of the fracture was checked using intraoperative fluoroscopy and noted to be excellent.

Next, a Synthes 7-hole 1/3 tubular plate was bent to follow contours of the fibula and applied and using standard operating technique. The distal 3 holes were filled with 4.0 mm cancellous screws, the proximal 3 holes were filled with 3.5 mm cortical screws. Placement of the hardware was checked under intraoperative fluoroscopy and noted to be excellent. Also, the ankle was stressed under live fluoroscopy, the syndesmosis was noted to be stable. However, there is noted to be gapping in the medial malleolus and the medial clear space. The lateral incision was then flushed with copious amounts of sterile Normal Saline. The periosteal tissues were reapproximated with 2-0 Vicryl. Subcutaneous tissues were reapproximated 3-0 Vicryl. Skin was reapproximated with staples.

Attention was directed to the medial aspect of the ankle where the medial malleolus was palpated. A 3 cm linear longitudinal incision was made overlying the medial malleolus. Incision was deepened to subcutaneous tissue with care taken to identify and retract neurovascular structures. The rupture of the deltoid ligament was directly identified and it was noted that the medial aspect of the joint was visible. Next, using 0 Vicryl to the deltoid ligament was repaired with 4 figure-of-eight sutures. The wound was then flushed with copious amounts of sterile Normal Saline. Subcutaneous tissues were reapproximated with 3-0 Vicryl. Skin was reapproximated with skin staples.

The wounds were then covered with Betadine-soaked Owen silk, sterile 4x4s, and Kerlix in the formation of moderate compression dressing. The tourniquet was deflated at this time with immediate hyperemic response being noted to all toes of the right foot. Next, a posterior splint was applied consisting of Webril 4-inch ortho glass and 4 and 6-inch Ace bandages. Anesthesia was discontinued at this time and the patient was transported to the PACU for postoperative monitoring with vital signs stable and vascular status intact to the right foot. The patient was instructed to be nonweightbearing and was readmitted to the floor and is to follow up upon discharge with Dr. Sean Wilson.

This case was performed in a teaching fashion. Dr. Wilson was present through the entire procedure including preoperatively and postoperatively and available to answer any questions for the patient and/or family.

Electronically Authenticated
Sean E Wilson/ESA, DPM 06/10/2010 11:46
Signing Provider
Dictating Provider Sean E Wilson/ESA, DPM

West Allis Memorial Hospital
Aurora Health Care
West Allis, WI

MRN: WMH-00275564
Patient Name: BRANNON, MARYANN
DOB: 09/29/1951
Case #: WMH-08000657116
Admit Date: 06/02/2010
Discharge Date: 06/04/2010
Pt. Loc/Type/Room: 3P2-WAMH Inpatient 306

Signed By:
Rupprecht, Christine M 06/03/10 13:08
Rupprecht, Christine M 06/03/10 13:28

Radiology Imaging Diagnostic

Exam	Exam Date/Time	Accession Number	Ordering Provider
DX Chest 1 View AP or PA	06/02/2010 20:30:21	DX-10-0449522	Munim, Shahida R

Reason for Exam

Pre-OP

DX Report

ONE-VIEW CHEST

Indication: Trimalleolar fracture. Preoperative exam.

Findings: Portable AP chest is submitted without comparison. The lungs are clear. The heart size and pulmonary vascularity are normal.

IMPRESSION:

No acute abnormality.

****

Dictated By: Reabe MD, Scott M

Electronically Signed By: Reabe MD, Scott M

Signed Date/Time: 06/03/10 13:32:45

Transcribed By:/Transcribed Date Time: WR , 06/03/10 09:12:52

West Allis Memorial Hospital

West Allis, WI

MRN: WMH-00275564
Patient Name: BRANNON, MARYANN
DOB: 09/29/1951
Case #: WMH-08000657116
Admit Date: 06/02/2010
Discharge Date: 06/04/2010
Pt. Loc/Type/Room: 3P2-WAMH Inpatient 306

Exam	Exam Date/Time	Accession Number	Ordering Provider
DX Ankle 3 View Min BILATERAL	06/02/2010 13:25:58	DX-10-0448051	Dillig, Cari L

Reason for Exam

Trauma

DX Report

BILATERAL ANKLES, 6/2/10

Indication: Trauma.

Right Ankle:

Mildly oblique, but primarily transverse fractures seen involving the distal right fibula just at and above the ankle joint. There is approximately 5 mm of posterior subluxation of the distal fracture fragment. No evidence for medial malleolar fracture, but there appears to be a posterior malleolar fracture measuring on the order of 1.8 cm in greatest dimension which is distracted somewhat posteriorly on the order of several millimeters. It is somewhat difficult to visualize, and additional oblique views would probably be helpful in further evaluation. There is mild to moderate soft tissue swelling at the lateral malleolus. The ankle mortise is not widened. Bony mineralization is normal. There is a small calcaneal spur.

CONCLUSION:

Acute fractures involving the distal right fibular metaphysis and the posterior malleolus. Some additional oblique views would be helpful in further evaluation of the posterior malleolar fracture.

Left Ankle:

No evidence for fracture, subluxation, or dislocation. No arthritic changes. There is a small calcaneal spur.

CONCLUSION:

PT Daily Assessment
06/03/10 07:40 am Performed by Lehky, Kelly E
Entered on 06/03/10 07:49 am

Pain Interventions

Non-Pharmocological Used	Yes
Comment Y/N Non-pharm	No
Comfort Measures	Elevation, Ice Pack(s), Relaxation/Rest/Sleep, Repositioning
Comment Y/N Comfort Measures	No

Intervention Evaluation

Pain Re-Assessment	Pain Not Acceptable (4-10 score)
Comment Y/N Pain Intervention	Yes
Pain Reassessment Comments	reports 10/10 right ankle pain

Subjective

PT Subjective	pt reports 10/10 right ankle pain. left ankle 6/10 at rest. agreeable to get up. having surgery this morning on right ankle
PT Patient Personal Goal	return home
Rehab Comments Y/N Hospital Course PT	No

Observation/Cognition

Cognitive Skill Retraining - PT: Intact

Additional Cognition Grid - PT
- Following Directions: Intact
- Verbal Expression: Intact
- Memory: Intact

Neurological

Neurological Grid - PT
- Sensation: Intact

Light Touch Sensation Grid Comment: LE's

ROM/Strength

Active ROM Grid - PT
- RLE: Limited
- LLE: WFL

Active ROM RLE Limited - PT	right ankle s/p fracture
ROM/Strength - PT	Gross Strength is Within Functional Limits except as noted
ROM/Strength Comments - PT	bilat ankles NT due to pain; left ankle with full ROM though painful and did not MMT

Ther Ex/Treatments

Rehab - PT Ther Ex Supine	Ankle Pumps
Rehab - PT Ex Reps	10
Therapeutic Exercise Comments - PT	10 AP to LLE

Bed Mobility/Transfers

Bed Mobility Grid
- Supine to Sit: Min
- Sit to Supine: Min

PT Daily Assessment

06/03/10 07:40 am Performed by Lehky, Kelly E
Entered on 06/03/10 07:49 am

Bed Mobility/Transfers

Sitting Balance: Supervision	
Rehab - PT Bed Mobility Comments	asst for RLE due to pain
Transfers Grid	
Sit to Stand: Supervision	
Stand to Sit: Supervision	
Transfer Comment - PT	cues for hand placement; issued and fit for CAM boot on LLE in standing

Ambulation

Distance 1 (ft) - PT	2 sidesteps
Ambulate Assistance - PT	Min
Weight Bearing Assistive Device PT	Two Wheeled Walker
Ambulation Comments	use of CAM boot on LLE; NWB RLE and WW; limited due to pain in LLE in weightbearing
Assistance Required - PT	Balance, Safety, Cueing for Sequence

Equipment

PT Equipment Grid	
1. PT Equipment Date	06/03/10
PT Equipment Initials	kl
PT Equipment Note	has w/c and crutches; script for WW placed on chart

Teaching

Learning Session - Bed Mobility	Initial
Ready to Learn - Bed Mobility	Yes
Learner - Bed Mobility	Patient
Learning Method - Bed Mobility	Verbal
Learning Evaluation - Bed Mobility	Verbalizes Understanding, Needs Further Teaching
Learning Session - PT Transfers	Initial
Ready to Learn - PT Transfers	Yes
Learner - PT Transfers	Patient
Learning Method - PT Transfers	Verbal
Learning Evaluation - PT Transfers	Verbalizes Understanding, Needs Further Training
Learning Session - Ambulate	Initial
Ready to Learn - Ambulate	Yes
Learner - Ambulate	Patient
Learning Method - Ambulate	Verbal
Learning Evaluation Ambulate	Verbalizes Understanding, Needs Further Teaching

Goals

Evaluation Date - PT	06/03/10
Goal Set Date - Bed Mobility	06/03/10
Goal Assistance - Bed Mobility	modified independent
Goal Review Date - Bed Mobility	06/09/10
Goal Set Date - Transfer	06/03/10
Goals Assistance - Transfers	modified independent
Goal Review Date	06/09/10
Goal Set Date - Ambulate	06/03/10

Physical Medicine and Rehab

PT Daily Assessment
06/03/10 07:40 am Performed by Lehky, Kelly E
Entered on 06/03/10 07:49 am

Goals

Goal Assistance - Ambulate	modified independent 10 feet with WW
Goal Review Date - Ambulate	06/09/10
Goal Set Date - Home Pgm	06/03/10
Goal Assistance - Home Pgm	w/c moblity 50 feet modified independent
Goal Review Date - Home Pgm	06/09/10

Assessment/Plan

Assessment Comments - PT	pt currently supervision to min asst for mobility limited due to right ankle fracture and left ankle sprain. issued CAM boot and plated on LLE during session per orders. pt scheduled for surgery for right ankle this am. pt from home with her husband and anticipate pt will be able to return home with use of WW, w/c at d/c. PT will continue to follow and progress as ordered after surgery.
Rehab Comments Y/N Plan Next Session PT	Yes
Treatment Plan Comments - PT	need new orders post surgery; progress transfers and gait vs w/c mobility; turn in script for WW when signed (consider increase to BID if needed for d/c home)
Rehab Comments Y/N D/C Plan PT	Yes
Discharge Planning Comments - PT	pt from home with her husband in apartment
Therapist Recommendation for D/C PT	Continue Skilled Therapy
PT Treatment Plan	Therapeutic Exercises, Transfer Training, Gait Training, Pre-gait Training, Bed Mobility Training, Balance Activities, Patient/Family Teaching
POC: Frequency - PT	7 Days per Week
Rehab - PT Treatment Duration	LOS
Goals/POC: Patient Agreement PT	Patient Agrees w/Goals and Treatment Plan

Session Length/Location

Session Length - PT	56 MIN
Rehab-Bill Select AB	Alpha Billing
Rehab - PT Assessment	PT Assessment

Session Unit AB

Rehab-PT Therapy Visit	PT Therapy Visit
Rehab-Physical Therapy Eval AB	Evaluation
Rehab-Therapeutic Activities PT #Unit AB	3 units

PT Daily Assessment
06/04/10 08:00 am Performed by Wacker, Chris
Entered on 06/04/10 10:08 am

Updated on
06/04/10 12:29 pm by Wacker, Chris

Physical Medicine and Rehab

PT Daily Assessment
06/04/10 08:00 am Performed by Wacker, Chris
Entered on 06/04/10 10:08 am

PT Assessment Type

Rehab-Assessment Type PT	Daily Assessment

Dx/Precautions

Diagnosis	right trimalleolar fracture; left ankle sprain
Diagnosis Onset Date	06/02/10
Rehab Precautions	Weight Bearing
Precautions Comments	CAM boot to LLE
Weight Bearing Left	WBAT
Weight Bearing Right	Non-Weight Bearing

Pain Assessment

Pain Assessment Type	Assessment
Comment Y/N Pt Comfort/Function Goal	No
Pt Preferred Pain Tool/Cognitive Ability	Numeric Rating Scale
Pain Evaluation Control	Both
Pain Score at Rest	10
Pain Score with Activity	10
acute pain grid	
Acute Pain 1	
Acute Pain 1 Concern	Yes
Acute Pain 1 Descriptor	Bilateral
Acute Pain 1 Location	Ankle
Acute Pain 1 Quality	Discomfort
Acute Pain 1 Comments	right worse than left
Pain Interventions	Yes
Comment Y/N Pain	Yes
Pain Assessment Comments	10/10 pain on R, 7/10 pain on L
Auto Pain Control	1
Pain Pediatric Control	Adult Patient (18 years +)

Pain Interventions

Non-Pharmocological Used	Yes
Comment Y/N Non-pharm	No
Comfort Measures	Elevation, Ice Pack(s), Relaxation/Rest/Sleep, Repositioning
Comment Y/N Comfort Measures	No

Intervention Evaluation

Pain Re-Assessment	Pain Not Acceptable (4-10 score)
Comment Y/N Pain Intervention	No

Subjective

PT Subjective	Pt reports feeling of lightheadedness with mobility, states that she is hoping to go home when d/c'd
PT Patient Personal Goal	return home
Rehab Comments Y/N Hospital Course PT	No

PT Daily Assessment
06/04/10 08:00 am Performed by Wacker, Chris
Entered on 06/04/10 10:08 am

Observation/Cognition

Cognitive Skill Retraining - PT	Intact
Observation - PT	IV, Continuous Pulse Ox
Additional Cognition Grid - PT	
Following Directions: Intact	
Verbal Expression: Intact	
Memory: Intact	

Neurological

Neurological Grid - PT	
Sensation: Intact	
Light Touch Sensation Grid Comment	bilat LEs

ROM/Strength

Active ROM Grid - PT	
RLE: Limited	
LLE: Limited	
Active ROM RLE Limited - PT	immobilized R foot and ankle, otherwise WFL
Active ROM LLE Limited - PT	limited ankle mobility, painful

Ther Ex/Treatments

Rehab - PT Ther Ex Supine	Ankle Pumps
Rehab - PT Ex Sets	1
Rehab - PT Ex Reps	10
Therapeutic Exercise Comments - PT	L LE active ankle pumps within pain tolerance and AAROM eversion/dorsiflexion. Educated to avoid inversion

Vitals/Activity

Rehab - Pulse During Treatment	84
Rehab - O2 Sat During Treatment	100
Rehab - O2 Flow During Treatment	RA

Bed Mobility/Transfers

Bed Mobility Grid	
Supine to Sit: Min	
Sit to Supine: Min	
Sitting Balance: Min	
Rehab - PT Bed Mobility Comments	total assist to don CAM boot on L, min assist at R LE in and out of bed and to support for NWB in sitting.
Transfers Grid	
Sit to Stand: Min	
Stand to Sit: Min	
Standing Balance: Min, Supervision	
Transfer Comment - PT	assist to stabilize WW and support R LE in NWB for sit to stand; min assist initially to support R LE in NWB in standing at WW, becoming supervision

PT Daily Assessment
06/04/10 08:00 am Performed by Wacker, Chris
Entered on 06/04/10 10:08 am

Ambulation

Weight Bearing Assistive Device PT	Two Wheeled Walker
Ambulation Comments	attempted 1 step forward and backward, very painful in both feet, needing to return to sitting then supine.

Equipment

PT Equipment Grid

1. PT Equipment Date	06/03/10
PT Equipment Initials	kl
PT Equipment Note	has w/c and crutches; script for WW placed on chart

Teaching

Learning Session - Bed Mobility	Reinforcement
Ready to Learn - Bed Mobility	Yes
Learner - Bed Mobility	Patient
Learning Method - Bed Mobility	Verbal
Learning Evaluation - Bed Mobility	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Learning Session - PT Transfers	Reinforcement
Ready to Learn - PT Transfers	Yes
Learner - PT Transfers	Patient
Learning Method - PT Transfers	Verbal
Learning Evaluation - PT Transfers	Verbalizes Understanding, Returns Demonstration, Needs Further Training
Learning Session - Ambulate	Reinforcement
Ready to Learn - Ambulate	Yes
Learner - Ambulate	Patient
Learning Method - Ambulate	Verbal
Learning Evaluation Ambulate	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Learning Session - Home Program PT	Initial
Ready to Learn - Home Program PT	Yes
Learner - Home Program PT	Patient
Learning Method - Home Program PT	Verbal
Learning Evaluation Home Program PT	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching

Goals

Goals Reviewed - PT	Reviewed/Unchanged
Evaluation Date - PT	06/03/10
Goal Set Date - Bed Mobility	06/03/10
Goal Assistance - Bed Mobility	modified independent
Goal Review Date - Bed Mobility	06/09/10
Goal Set Date - Transfer	06/03/10
Goals Assistance - Transfers	modified independent
Goal Review Date	06/09/10
Goal Set Date - Ambulate	06/03/10
Goal Assistance - Ambulate	modified independent 10 feet with WW

PT Daily Assessment
06/04/10 08:00 am Performed by Wacker, Chris
Entered on 06/04/10 10:08 am

Goals

Goal Review Date - Ambulate	06/09/10
Goal Set Date - Home Pgm	06/03/10
Goal Assistance - Home Pgm	w/c moblity 50 feet modified independent
Goal Review Date - Home Pgm	06/09/10

Assessment/Plan

Assessment Comments - PT	Pt seen today following surgery; is below baseline for mobility. Pt limited by pain in both ankles, continues to be NWB on R and WBAT with CAM boot on L. Pt needing min assist with bed mobility, transfers, and standing to assist with R LE movement and support against gravity. Pt limited in ability to take steps once standing. Pt planning d/c home when stable but will continue to monitor progress to assist with d/c planning. Pt increased to BID to promote d/c home following surgery
Rehab Comments Y/N Plan Next Session PT	Yes
Treatment Plan Comments - PT	progress transfers and gait vs w/c mobility; turn in script for WW when signed. (modified)
Rehab Comments Y/N D/C Plan PT	Yes
Discharge Planning Comments - PT	pt from home with her husband in apartment (modified)
Therapist Recommendation for D/C PT	Continue Skilled Therapy
PT Treatment Plan	Therapeutic Exercises, Transfer Training, Gait Training, Pre-gait Training, Bed Mobility Training, Balance Activities, Patient/Family Teaching
POC: Frequency - PT	Twice Daily (modified)
Rehab - PT Treatment Duration	LOS
Goals/POC: Patient Agreement PT	Patient Agrees w/Goals and Treatment Plan

Session Length/Location

Session Length - PT	45 MIN
Rehab-Bill Select AB	Alpha Billing
Rehab - PT Assessment	PT Assessment

Session Unit AB

Rehab-PT Therapy Visit	PT Therapy Visit
Rehab-Therapeutic Activities PT #Unit AB	3 units

PT Daily Assessment
06/04/10 01:30 pm Performed by Wacker, Chris
Entered on 06/04/10 03:15 pm

PT Assessment Type

Rehab-Assessment Type PT	Daily Assessment

PT Daily Assessment
06/04/10 01:30 pm Performed by Wacker, Chris
Entered on 06/04/10 03:15 pm

Dx/Precautions

Diagnosis	right trimalleolar fracture; left ankle sprain, s/p ankle ORIF
Diagnosis Onset Date	06/02/10
Rehab Precautions	Weight Bearing
Precautions Comments	CAM boot to LLE
Weight Bearing Left	WBAT
Weight Bearing Right	Non-Weight Bearing

Pain Assessment

Pain Assessment Type	Assessment
Comment Y/N Pt Comfort/Function Goal	No
Pt Preferred Pain Tool/Cognitive Ability	Numeric Rating Scale
Pain Evaluation Control	Both
Pain Score at Rest	10
Pain Score with Activity	10
acute pain grid	
Acute Pain 1	
Acute Pain 1 Concern	Yes
Acute Pain 1 Descriptor	Bilateral
Acute Pain 1 Location	Ankle
Acute Pain 1 Quality	Discomfort
Acute Pain 1 Comments	right worse than left
Pain Interventions	Yes
Comment Y/N Pain	No
Auto Pain Control	1
Pain Pediatric Control	Adult Patient (18 years +)

Pain Interventions

Non-Pharmocological Used	Yes
Comment Y/N Non-pharm	No
Comfort Measures	Brace/Support/Sling, Elevation, Family's Presence, Ice Pack(s), Relaxation/Rest/Sleep, Repositioning
Comment Y/N Comfort Measures	No

Intervention Evaluation

Pain Re-Assessment	Pain Not Acceptable (4-10 score)
Comment Y/N Pain Intervention	No

Subjective

PT Subjective	Pt states that she is not confident about going home tomorrow.
PT Patient Personal Goal	return home
Rehab Comments Y/N Hospital Course PT	No

Vitals/Activity

Rehab - Pulse During Treatment	83
Rehab - O2 Sat During Treatment	95
Rehab - O2 Flow During Treatment	RA

PT Daily Assessment
06/04/10 01:30 pm Performed by Wacker, Chris
Entered on 06/04/10 03:15 pm

Bed Mobility/Transfers	
Bed Mobility Grid	
Supine to Sit: Min	
Sit to Supine: Min	
Sitting Balance: Independent	
Rehab - PT Bed Mobility Comments	min assist to bring R LE to EOB for supine to sit and L LE into bed for sit to supine. Spouse was available to observe and be educated on bed mobility
Transfers Grid	
Sit to Stand: Supervision	
Stand to Sit: Supervision	
Stand - Pivot: Supervision	
Standing Balance: Supervision	
Transfer Comment - PT	supervision for safety with pt transferring to standing at WW and pivoting on L LE to chair at bedside. Pt able to maintain NWB on R LE. Pt transferred to and from chair and bed. Spouse was available to observe and be educated on transfer technique.
Ambulation	
Distance 1 (ft) - PT	3
Ambulate Assistance - PT	Supv
Weight Bearing Assistive Device PT	Two Wheeled Walker
Ambulation Comments	pt able to take several steps with WW and NWB on R LE from bed to chair, painful.
Equipment	
PT Equipment Grid	
1. PT Equipment Date	06/03/10
PT Equipment Initials	kl
PT Equipment Note	has w/c and crutches; script for WW placed on chart
2. PT Equipment Date	06/04/10
PT Equipment Initials	cw
PT Equipment Note	equipment delivered
Teaching	
Learning Session - Bed Mobility	Reinforcement
Ready to Learn - Bed Mobility	Yes
Learner - Bed Mobility	Patient
Learning Method - Bed Mobility	Verbal
Learning Evaluation - Bed Mobility	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Learning Session - PT Transfers	Reinforcement
Ready to Learn - PT Transfers	Yes
Learner - PT Transfers	Patient
Learning Method - PT Transfers	Verbal

PT Daily Assessment

06/04/10 01:30 pm Performed by Wacker, Chris
Entered on 06/04/10 03:15 pm

Teaching

Learning Evaluation - PT Transfers	Verbalizes Understanding, Returns Demonstration, Needs Further Training
Learning Session - Ambulate	Reinforcement
Ready to Learn - Ambulate	Yes
Learner - Ambulate	Patient
Learning Method - Ambulate	Verbal
Learning Evaluation Ambulate	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Learning Session - Home Program PT	Reinforcement
Ready to Learn - Home Program PT	Yes
Learner - Home Program PT	Patient
Learning Method - Home Program PT	Verbal
Learning Evaluation Home Program PT	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching

Goals

Goals Reviewed - PT	Reviewed/Unchanged
Evaluation Date - PT	06/03/10
Goal Set Date - Bed Mobility	06/03/10
Goal Assistance - Bed Mobility	modified independent
Goal Review Date - Bed Mobility	06/09/10
Goal Set Date - Transfer	06/03/10
Goals Assistance - Transfers	modified independent
Goal Review Date	06/09/10
Goal Set Date - Ambulate	06/03/10
Goal Assistance - Ambulate	modified independent 10 feet with WW
Goal Review Date - Ambulate	06/09/10
Goal Set Date - Home Pgm	06/03/10
Goal Assistance - Home Pgm	w/c moblity 50 feet modified independent
Goal Review Date - Home Pgm	06/09/10

Assessment/Plan

Assessment Comments - PT	Pt below baseline for mobility. Pt needing min assist with bed mobility and total assist with putting cam boot on. Spouse available and educated on providing assitance and CAM boot application. Pt able to transfer to standing and pivot to chair and back with supervision using WW while maintaining R NWB for transfer. Anticipate pt will be able to d/c home using stand pivots to WC to get to bed and toilet and will follow-up with home PT to progress mobility at home, pt voiced doubt that she was ready.
Rehab Comments Y/N Plan Next Session PT	Yes
Treatment Plan Comments - PT	if still here, practice stand pivot transfers to WC, WC mobility, progress ambulation
Rehab Comments Y/N D/C Plan PT	Yes
Discharge Planning Comments - PT	pt from home with her husband in apartment
Therapist Recommendation for D/C PT	Continue Skilled Therapy

Physical Medicine and Rehab

PT Daily Assessment
06/04/10 01:30 pm Performed by Wacker, Chris
Entered on 06/04/10 03:15 pm

Assessment/Plan

PT Treatment Plan	Therapeutic Exercises, Transfer Training, Gait Training, Pre-gait Training, Bed Mobility Training, Balance Activities, Patient/Family Teaching
POC: Frequency - PT	Twice Daily
Rehab - PT Treatment Duration	LOS
Goals/POC: Patient Agreement PT	Patient Agrees w/Goals and Treatment Plan

Session Length/Location

Session Length - PT	30 MIN
Rehab-Bill Select AB	Alpha Billing
Rehab - PT Assessment	PT Assessment

Session Unit AB

Rehab-PT Therapy Visit	PT Therapy Visit
Rehab-Therapeutic Activities PT #Unit AB	2 units

OT Daily Assessment
06/03/10 03:45 pm Performed by Prell, Kathryn M
Entered on 06/03/10 03:47 pm

OT Assessment Type

Rehab-Assessment Type OT	Daily Assessment

Dx/Precautions

Diagnosis	right trimalleolar fracture; left ankle sprain
Rehab Precautions	Weight Bearing
Precautions Comments	CAM boot to LLE
Weight Bearing Left	WBAT
Weight Bearing Right	Non-Weight Bearing

Assessment/Plan

Assessment Comments - OT	attempted to see pt, pt had just returned from sx. No new orders in chart, RN notified.
Rehab Comments Y/N Plan Next Session OT	Yes
Treatment Plan Comments - OT	await new orders and eval pt
Rehab Comments Y/N D/C Plan OT	No

Session Length/Location

Session Length - OT	0 MIN
Other Treatments Comments - OT	awaiting new orders post sx
Rehab - OT Assessment	OT Assessment

OT Daily Assessment
06/04/10 11:00 am Performed by Prell, Kathryn M
Entered on 06/04/10 12:48 pm

OT Assessment Type

Rehab-Assessment Type OT	Evaluation

Dx/Precautions

Diagnosis	right trimalleolar fracture; left ankle sprain, s/p ankle ORIF
Diagnosis Onset Date	06/02/10
Rehab Precautions	Weight Bearing
Precautions Comments	CAM boot to LLE
Weight Bearing Left	WBAT
Weight Bearing Right	Non-Weight Bearing

Prior Mobility

Rehab Prior Mobility Review Type	Reviewed/Unchanged
Rehab Prior Mobility Review/Modify DT	06/03/10
Number of Steps Into Home	0
Number of Steps In Home	0
Home Layout Use	Uses First Floor

Prior Mobility Grid
- Bed Mobility: Independent
- Transfers: Independent
- Amb - Home: Independent
- Amb - Community: Independent
- Steps into Home: Independent
- Steps within Home: Independent
- Car Transfers: Independent

Prior Living Situation

Rehab Prior Living Review Type	Reviewed/Unchanged
Rehab Prior Living Review/Modify DT	06/04/10
Living Situation - Rehab	Spouse
Living Environment	Apartment
Rehab Prior Living Support System	Spouse, Family
Living Situation Comments - Rehab	spouse works part time
Baseline Information - Rehab	Patient

Prior ADL's

Rehab ADLs Review Type	Reviewed/Unchanged
Rehab Prior ADLs Review/Modify DT	06/04/10

ADL Grid
- Feeding and Eating: Independent
- Grooming: Independent
- Oral Hygiene: Independent
- Upper Ext Bathing: Independent
- Lower Ext Bathing: Independent
- Upper Ext Dressing: Independent
- Lower Ext Dressing: Independent
- Walk-in Shower: Not Applicable
- Tub Shower: Independent
- Tub Bath: Not Applicable

OT Daily Assessment
06/04/10 11:00 am Performed by Prell, Kathryn M
Entered on 06/04/10 12:48 pm

Prior ADL's
- Sink Side Bathing: Not Applicable
- Toilet Transfer: Independent
- Toilet Hygiene: Independent
- Homemaking Skills: Independent
- Meal Preparation: Independent
- Home Cleaning: Independent
- Laundry: Independent
- Shopping: Independent

Pain Assessment

Pain Assessment Type	Assessment
Comment Y/N Pt Comfort/Function Goal	Yes
Patient Comfort/Function Goal Comment	pain in RLE with activity and at rest, pain medication at begining of session, use of PCA
Pt Preferred Pain Tool/Cognitive Ability	Numeric Rating Scale
Pain Evaluation Control	Both
Pain Score at Rest	7
Pain Score with Activity	8
acute pain grid	
Acute Pain 1	
Acute Pain 1 Concern	Yes
Acute Pain 1 Descriptor	Bilateral
Acute Pain 1 Location	Ankle
Acute Pain 1 Quality	Discomfort
Acute Pain 1 Comments	right worse than left
Pain Interventions	Yes
Comment Y/N Pain	No
Auto Pain Control	1
Pain Pediatric Control	Adult Patient (18 years +)

Pain Interventions

Non-Pharmocological Used	Yes
Comment Y/N Non-pharm	No
Comfort Measures	Brace/Support/Sling, Elevation, Ice Pack(s), Relaxation/Rest/Sleep, Repositioning
Comment Y/N Comfort Measures	No

Intervention Evaluation

Pain Re-Assessment	Pain Not Acceptable (4-10 score)
Comment Y/N Pain Intervention	Yes
Pain Reassessment Comments	pain in RLE with activity and at rest, pain medication at begining of session, use of PCA, elevation

Subjective

OT Subjective	tearful about returning home and not having assist she needs, "I won't go to rehab."
Rehab Comments Y/N Hospital Course OT	Yes
Rehab - OT Hospital Course	6/3: ankle sx

OT Daily Assessment

06/04/10 11:00 am Performed by Prell, Kathryn M
Entered on 06/04/10 12:48 pm

Observation/Cognition

Cognition Impaired - OT	Intact
Observation	IV, Continuous Pulse Ox
Additional Cognition Grid - OT	
Following Directions: Intact	
Verbal Expression: Intact	
Memory: Intact	

ROM/Strength

Active ROM Grid - OT	
RUE: WFL	
R Hand: WFL	
LUE: WFL	
L Hand: WFL	
ROM/Strength - OT	Gross Strength is Within Functional Limits

Vitals/Activity

Rehab - Activity Tolerance Comments	able to tolerate pain

Household Mobility

OT Mobility Transfer Grid	
Bed Transfer: Supv	
Chair - with arms: Min	
Rehab - OT Chair Transfer w/ Arms Grid C	assist for balance and safety, stand pivot transfer from bed to commode and return, NWB on RLE, use of ww

Home Management Skills

Rehab - OT Home Mgmt Comment	pt reports husband "will have to" complete IADLs

Self Cares/ADL's

ADL Daily Grid	
Lower Ext Dressing: Mod	
Toileting: Modified Independent	
Toilet Transfer: Min	
Rehab - OT Low Ext Dressing Grid Comment	pt needing assist for positioning, assist to pull over hips, cues for use of AE
Rehab - OT Toileting Grid Comment	in seated position
Rehab - OT Toilet Xfer Grid Comment	assist for balance and safety, stand pivot transfer from bed to commode and return, NWB on RLE, use of ww
OT Self-Care/ADLs Comment	discussed need to spongebathe

Equipment

OT Equipment Grid	
1. OT Equipment Date	06/04/10
OT Equipment Initials	KP
OT Equipment Note	order reacher and commode chair
OT Vendor Choices	Patient provided with vendor choices

OT Daily Assessment

06/04/10 11:00 am Performed by Prell, Kathryn M
Entered on 06/04/10 12:48 pm

Teaching	
Learning Session - ADLs	Initial
Ready to Learn - ADLs	Yes
Learner - ADLs	Patient
Learning Method - ADLs	Verbal
Learning Evaluation - ADLs	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Discipline Teaching ADLs	OT
Learning Session - OT Transfers	Initial
Ready to Learn - OT Transfers	Yes
Learner - OT Transfers	Patient
Learning Method - OT Transfers	Verbal
Learning Evaluation - OT Transfers	Verbalizes Understanding, Returns Demonstration, Needs Further Teaching
Discipline Teaching OT Transfers	OT
Goals	
Goals Reviewed - OT	Reviewed/Updated
Evaluation Date - OT	06/04/10
Goal Set Date - ADLs OT	06/04/10
Goal Assistance - ADLs OT	mod I for spongebathing
Goal Review Date - ADLs OT	06/11/10
Goal Set Date - Transfer OT	06/04/10
Goal Assistance - Transfer OT	mod I for commode tranafer
Goal Review Date - Transfer OT	06/11/10
Goal Set Date - Lower Body OT	06/04/10
Goal Assistance - Lower Body OT	mod I for LB dressing with AE
Goal Review Date - Lower Body OT	06/11/10
Goal Set Date - Toileting OT	06/04/10
Goal Additional Toileting - OT	mod I for toileting cares
Goal Review Date - Toileting OT	06/11/10
Assessment/Plan	
Assessment Comments - OT	pt below baseline of independent and is planning to return home. Pt would benefit from home OT and home care aide as husband works part-time. Pt tearful during session and concerned about returning home today. Ordered AE.
Rehab Comments Y/N Plan Next Session OT	Yes
Treatment Plan Comments - OT	review LB dressing, commode transfer, AE received?
Rehab Comments Y/N D/C Plan OT	Yes
Discharge Planning Comments - OT	from home with husband, baseline independent, plan to return home with home OT and home care aide, husband works part-time,
Therapist Recommendation for D/C OT	Continue Skilled Therapy
OT Treatment Plan	ADL Self Care Retraining, Adaptive Equipment, Energy Conservation, Family/Caregiver Teaching, Home Management, Safety Training, Therapeutic Activities, Therapeutic Exercises, Transfer

OT Daily Assessment

06/04/10 11:00 am Performed by Prell, Kathryn M
Entered on 06/04/10 12:48 pm

Assessment/Plan

	Training
Frequency Rehab Goals - OT	7 Days per Week
Rehab - OT Treatment Duration	LOS
Goals and Treatment Plan - OT	Patient Agrees w/Goals and Treatment Plan

Session Length/Location

Session Length - OT	60 MIN
Rehab-Bill Select AB	Alpha Billing
Rehab - OT Assessment	OT Assessment

Session Unit AB

Rehab-OT Therapy Visit	OT Therapy Visit
Rehab-Occupational Therapy Eval AB	Evaluation
Rehab-ADL/Self Care OT #Unit AB	3 units

Social Services Assessment Form

Social Work/CM Assessment Form
06/04/10 01:30 pm Performed by Choinski, Donna
Entered on 06/04/10 04:27 pm

Progress Note

SSVC Progress Note	6-4-10 Donna M. Choinski RN CCC 205-2324 MD order for home therapy. Received call from aspen orthopedic office yesterday indicating that they already made a referral to Gentiva Home Health for this pt. Chart reviewed. Pt is 58 years old. Admitted for bilateral trimalleolar fractures on 6-2-10. Per OPT rounds right ankle was fractured and left ankle was sprained. Pt had an ORIF of the right ankle on 6-3-10. Therapy indicated home therapy is appropriate for pt. Met with pt earlier today. She lives with her husband in their apartment. She agrees with home therapy and is willing to use Gentiva since her physician ordered it. Gentiva referral form was placed on front of chart. Called Gentiva earlier today and gave them preliminary referral information. Pt was discharged home this afternoon. Gentiva was informed. Gentiva will contact pt at home to arrange time for initial visit. Called pt at home and informed her that Gentiva will be calling her. RN faxed final referral paperwork to Gentiva at time of discharge.

Demographics

SSVC Referral Source	MD
SSVC Referral Date	06/04/10
SSVC Referral Reason	D/C Plan, New Home Care
SSVC Information Source	Current Medical Record, Patient
Primary Language	English
SSVC Employment Status	Disabled, Unemployed
SSVC Marital Status	Married
Contact Person Grid	
1. Contact Person Name	FRED BRANNON
Contact Person Relationship	Spouse
Contact Person Primary Number	414-779-9945

Interview

SSVC Interview	Patient
SSVC Mental PTA	Alert, Oriented to Person, Oriented to Place, Oriented to Time
SSVC Mental Now	Alert, Oriented to Person, Oriented to Place, Oriented to Reason for Hospitalization, Oriented to Time
SSVC Patient Communication	Cooperative, Pleasant
SSVC Living Situation	Spouse, Apartment

Agency/Supports/Coping

SSVC Formal Support	None
SSVC Informal Support	Family

West Allis Memorial Hospital
Aurora Health Care
West Allis, WI

MRN: WMH-00275564
Patient Name: BRANNON, MARYANN
DOB: 09/29/1951
Case #: WMH-08000657116
Admit Date: 06/02/2010
Discharge Date: 06/04/2010
Pt. Loc/Type/Room: 3P2-WAMH Inpatient 306

Social Services Assessment Form

Social Work/CM Assessment Form
06/04/10 01:30 pm Performed by Choinski, Donna
Entered on 06/04/10 04:27 pm

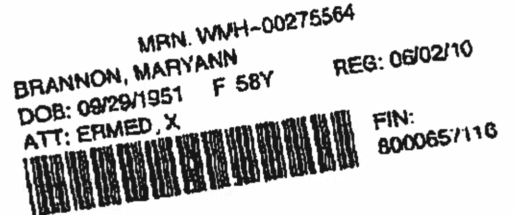
Discharge/Care Plan

SSVC Patient D/C Goal	Discharge/Referral Needs
SSVC Plan Status	Anticipated Aftercare Needs
SSVC Plan	Home
SW Plan Services Grid	
1. SW Plan Services	Home Health-Skilled
SW Plan Services Comment	Gentiva
SSVC Plan Needs	None Identified
SSVC Agree to Goal	Patient Agrees and understands Goals and Plan

Medication Administration Record

Aurora Health Care® Milwaukee, Wisconsin

☐ AHCM-AS ☐ AHCM-SS ☒ AWAMC ☐ AMG (site)
☐ AHCM-SL ☐ AMCWC ☐ AUWAMG



Date: 6-2-10 Age: 58 D.O.B. 09.29.1961
Patient's Name: Mary Ann.
PMD/Clinic:
ROOM # FTA 1
Here Before: ☐ Workman's Comp: ☐

Pre-Arrival: ☐ FULLY IMMOBILIZED ☐ SPLINTED ☐ O2 ☐ CPR ☐ DEFIBRILLATED ISOLATION ____/TIME ____ x ____ ☐ BS ____ GCS ____
Treatment: ☐ INTUBATED ☐ IV ☐ Meds:
Arrival Mode: ☐ Walk ☐ Wheelchair ☐ Cart ☐ Carried ☒ Ambulance Bell 433 ☐ In Police Custody ☐ Refusal Form Signed
Triage Treatment: ☐ SPLINT ☐ ELEVATION ☐ COLD PACK ☐ FULLY IMMOBILIZED ☐ C COLLAR ☐ DRESSING ☐ Mask Given

EMS/ED
Pre-Arrival time:
Triage time: 1135
ED MD notified: 1140
Time in room: 1140
Time seen by MD: 1150
Time left ED:

PRE-ARRIVAL/TIME

Emergency Severity Index: 1 2 3 (4) 5

CC: (R) ankle pain

Interpreter called / Time

TRIAGE NOTE: 58 y/o F (L) standing fall "10/10"

☐ Waiting in Lobby/Patient Aware

TRIAGE RN: [signature] Keller

Visual Acuity Time/Int ____
Correction: ☐ w/o ☐ with
Right Eye 20/
Left Eye 20/
Both Eyes 20/

Wt: ____ kg

Immunizations
Last Tetanus:
Peds Shots up to date: ☐ Yes ☐ No

Other Hx
Birth Control:
LMP:
G__ P__ ?__ A__ L__

Medical History ☐ Denies
☐ Arthritis ☒ Asthma ☐ CAD / PVD ☐ Cancer ☐ CHF ☐ Cholesterol ☐ Chronic Pain ☐ COPD ☐ CVA / TIA ☐ Dementia ☐ Diabetes
☐ GERD ☐ HTN ☐ Kidney/Dialysis ☐ Kidney Stone ☐ Mental Illness ☐ MI ☐ Seizures ☐ Sickle Cell ☐ Thyroid ☐ Valve Disease
Other:

Surgical History ☐ Denies
☐ Adenoids ☐ Angioplasty/Stent ☐ Appendix ☐ CABG ☐ C-Section ☐ Gallbladder ☐ Gastric Surgery ☐ Other:
☐ Hernia ☐ Hysterectomy ☐ Ortho ☐ Pacer / AICD ☐ Tonsillectomy ☐ Transplant ☐ Tubal Ligation

TIME	EMS	1140	1250
BP	188/80	140/82	133/86
P	88	96	86
R	18	16	16
T	|	99.0	|
SaO2 / O2/RA	|	98% RA	99% RA

EDUCATIONAL NEEDS ✓
PAIN 10/10
Goal 2/10
SAFETY ✓
SAFETY PLAN ☐ Yes ☐ No
PSYCHO-SOCIAL ✓
ABUSE ✓
RESP
SKIN
NEURO
GCS
MUSCULO-SKELETAL ✓
GI
CV/PV
GU
E ENT
Time 1140 Initials QB

Social History ☐ Denies
Tobacco:
ETOH:
Illicit Drugs:

[circled] RM 30

ALLERGIES ☐ NKDA ☒ Latex ☐ Unknown
☐ Environmental
ASA Darvon
Keflex cyclobenzaprine
Nubaine

MEDICATIONS: ☐ Denies ☐ Unknown
☐ See Reconciliation Form
~~ASA~~ albuterol
Singulair
~~Ceptek~~

☐ Police Notified

TIME:
Bilat ankle pain + swelling — QB
CMS intact distal
1300 - given 6mg morphine IM
(R) thigh - 10/10 pain — QB
1250 pain 9/10 however, very sleepy
& slow to respond
~~1500 Report to Brooke~~ — QB
1815 Pt placed on bed pan

INITIAL	SIGNATURE
	[signature], RN
QB	QB [signature]

EMERGENCY DEPARTMENT RECORD
(H&P / Emer)

White - Medical Records / Yellow - Department
Pink - Physician Billing
AHC 05403970 .I (Rev. 05/09) Front

Aurora Health Care Milwaukee, Wisconsin

☐SLMC ☐SLSS ☐WAMH

MRN: WMH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG 06/02/10
ATT: Dillig, Cari L

FIN: 8000657116

Ankle / Foot Injury #44

Check ✓ if WNL, circle positives, slash negatives or negatives, mark ☐ for test ordered or tasks done

Date: 6/2/10 Time Seen: 1150 PMD:

T: 98° BP: 140/82 P: 86 RR: 18 POX (%): 98%

MD Time Seen Timestamp

Chief Complaint: Injury to: right / left / ankle / foot / toes: 1 2 3 4 5

laceration / contusion / sprain / pain / fracture / deformity /

HPI: (L= Level of Service) L1-3: 1-3 elements; L4-5: 4+ elements

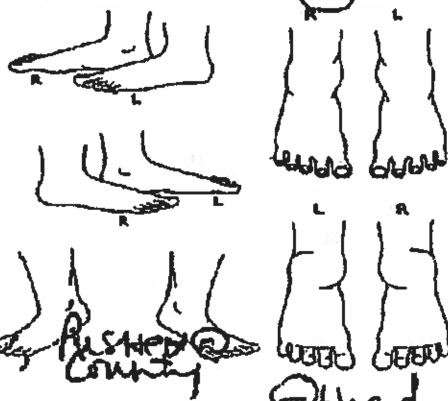
Historian: patient / family / friend / EMS / interpreter /
Hx & ROS limited by: altered mental status / acuity / intoxication / dementia / age
Referred by: self / clinic / PMD / family / EMS /
Arrived by: EMS / walk-in / wheelchair / police / car driven by: self / friend / family
Advanced Directive: none / DNR / "full code" / comfort care /

Onset: sudden / gradual / unsure

Began: ______ time ______ date today / yesterday
1/2 minutes / hrs / days / weeks / months prior to arrival

Location:

Leg: right / left
Knee: right / left
Ankle: right / left
Foot: right / left
Toes: right great #2 #3 #4 #5
Toes: left great #2 #3 #4 #5



Activity During Injury: Fell from standing, pushed @ County

Locale: home / work / school /

⊖ Head
⊖ Neck / Back
⊖ Chest / Belly
⊖ Pelvis / Hips

Course / Timing / Duration: constant / intermittent
Course: same / fluctuating / worse / improved / resolved (time:
Duration-frequency of episodes:

Context: new problem / recurrent / chronic
If recurrent episode, last episode of similar:
If recurrent or chronic episode, current episode: same / not as bad / worse / worst ever

Character / Quality: can't describe
Mechanism: inversion / eversion / internal rotation / external rotation / hyperflexion
hyperextension / jam / fall / direct blow / crush / cut / burn / foreign body / fall
Injury description (quality): deformity / dislocation / sprain / strain / contusion /
laceration / abrasion / foreign body / stab / GSW / burn /
Pain: at rest / with weight bearing / with movement / with palpation
Pain quality: "pain" / sharp / dull / aching / throbbing /

Severity: can't describe
At max (0 to 10): ______ mild / moderate / severe
Now (0 to 10): ______ none / mild / moderate / severe

Associated Sx: ___ none
swelling (immediate / gradual / delayed > 24 hr) / numbness / weakness / pallor

Alleviated/Relieved by: ___ nothing
ice / elevation / rest / immobilization /

Aggravated/Exacerbated by: ___ nothing
weight bearing / movement /

Prior Tx: any / yes: cool compress / NSAID / EMS: splint /

Past Medical, Family, Social hx: L1-4: 1 area; L5: 2 of 3 areas

Allergy: ___ NKDA see ED record / latex / PCN / sulfa / contrast medium /
ASA, Darvon, Nubain, Cyclobenzaprine, K

Medications: ___ none see ED record aspirin / digoxin / coumadin

PMH / Surgical Hx: ___ none see ED record
arthritis / gout / DVT / superficial thrombophlebitis / venous stasis
HTN / hypercholesterolemia / NIDDM / IDDM / CAD / MI
PUD / gastritis / UGI bleed / LGI bleed Chole Hyst
prior (injury / surgery): ankle / foot / lower extremity
Asthma
Nephrolithiasis
/ Tetanus immunization current: yes / no

Social Hx: unknown
Tobacco use: ___ no yes ___ cigarettes / packs per day / week
ETOH: ___ no yes: ___ drinks per day / week Last ETOH: ______
Drug use: ___ no yes: cocaine / marijuana /
Occupation: unemployed / student / retired / employed:
Lives: house / apartment / homeless / homeless shelter / group home /
assisted living / nursing home /
Living situation: alone / significant other / children / parents /
Domestic Violence: ___ no yes:

Family Hx: noncontributory / unknown / IDDM / NIDDM / HTN / CAD

ROS: L1-3: 1 system; L4: 2-9 systems; L5: 10+ systems

☐ All 14 systems reviewed: ___ neg ✓ neg except as per HPI and/or circled be

✓ Constitutional: fever / chills / weakness
✓ Eyes: visual problems / redness
✓ ENT: sore throat / congestion / nosebleed
✓ CV: chest discomfort / palpitations / orthopnea / PND / ankle swelling
✓ Respiratory: SOB / hemoptysis / cough
✓ GI: abdominal discomfort / tarry stools / rectal bleeding / constipation
___ GU: dysuria / urgency / frequency / hematuria / kidney problems
LMP: ______ : ___ WNL abnormal
Oral Contraception: no / yes
✓ Musculoskeletal: other painful areas: Ø knee / Foot
✓ Skin: rash / skin problems
✓ Neurologic: gait abnormality / numbness / tingling
✓ Psychiatric: stress / anxiety / depression
✓ Hematology / Lymphatic: bruising / bleeding / swollen lymph nodes
___ Endocrine: polyuria / polydipsia / thyroid problems
✓ Immunology / Allergy: Immunosuppressant therapy / cancer

ED PHYSICIAN RECORD (H&P/ED)

Aurora Health Care• Milwaukee, Wisconsin

☐SLMC ☐SLSS ☐WAMH

Ankle & Foot Inury #44

MRN WWH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Dillig, Carl L
FIN: 8000657116

Physical Exam: L2-3: 2-4 organ/areas; L4: 5-7 organ/areas; L5: 8+ organ/areas

☒ VS Reviewed Exam limited by: urgency of condition / patient uncooperative
General: alert / lethargic / confused / obtunded Oriented: person / place / time
Anxious: mild / moderate / severe Distress: mild / moderate / severe
Nutritional status: WNL cachectic / obese Hydration: WNL dehydrated

Head atraumatic

Cardiovascular:
✓ regular rate and rhythm
✓ normal S1&S2, no murmur
___ DP& post tibialis pulse equal bil.
___ no palpable cords, negative Homan's

Respiratory:
✓ no respiratory distress
✓ lungs CTA bilaterally

Gastrointestinal / Abdomen / Back
✓ inspection and bowel sounds normal
✓ soft, non-tender, no masses

Skin
✓ no rash, no erythema, no cyanosis
✓ warm & dry, capillary refill < 2 sec
✓ no peripheral edema

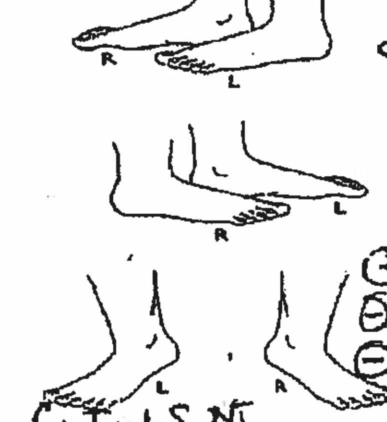
Lymphatic:
___ no inguinal, popliteal lymphadenopathy

Right Lower Extremity
✓ appearance WNL, no swelling/deformity
ROM full ŝ pain: ✓ knee ✓ ankle ✓ toes
Nontender: ✓ knee ✓ lower leg ✓ ankle ✓ foot ✓ toes
Stable: ✓ knee ✓ ankle ✓ toes
✓ muscle strength and tone intact
✓ light touch, sharp-dull sensation intact

Left Lower Extremity
(+) appearance WNL, no swelling/deformity
ROM full ŝ pain: ✓ knee ✓ ankle ✓ toes
Nontender: ✓ knee ✓ lower leg ✓ ankle ✓ foot ✓ toes
Stable: ✓ knee ✓ ankle ✓ toes
✓ muscle strength and tone intact
✓ light touch, sharp-dull sensation intact

PERRLA
Pharynx WNL

Comments:
BLE WNL
Stable Pelvis; Hips, Knees



Circle/point:
1= pain
2= tender
3= erythema
4= edema
5= ecchymosis
6= deformity
7= numbness
8= radiation

R L

(−) Prox Fib/Syndesmosis
(−) Achilles
(−) 5TH MT

Diagnostic Considerations: circle or write potential diagnoses
ankle sprain / muscle strain / compartment syndrome / tibia fx / fibula fx / dislocation of: ankle / toe / puncture wound / foreign body / 5th metatarsal fx / ankle fx / toe fx / laceration / Achilles tendon injury / contusion of: ankle / toe

Radiology:
☒ 1- right / left / ankle / foot / toe # ___ / ___ WNL — Trimalleolar Fx (L)
☐ 2- ___ WNL
☐ 1- Read by: ED MD / Radiology Report ☐ 2- Read by: ED MD / Radiology Report

Treatment / Management Options / Course:
☐ O2 at ___ L/minute / % FiO2 (NC, face mask, ___)
☒ IV cap / infusion (NS, ___): Bolus ___ mL; Rate ___ mL/hr
☐ Acetaminophen / Ibuprofen ___ mg PO ☐ Vicodin / Percocet 1 / 2 PO
☒ Morphine sulfate 8 mg IV / IM total dose= ___ mg
☐ Procedural sedation: IV fentanyl / versed / propofol / etomidate / ___
☐ Dislocated joint reduction: (right / left) ankle / toe # ___ / ___
☐ Education: crutches / walker / wound management by MD / PA / ED Tech
☐ Splint: (stirrup / posterior short leg / ___) by MD / PA / ED Tech
☐ Wound dressing: topical antibiotic / bandage / Kerlex by MD / PA / ED Tech
☐ DT 0.5 ml IM

Ice
Short Leg / Crutches
ACE Wrap (L)

Isolated (L) ankle injury
R > L
(−) open
[illegible]

Pain Level: ___ /10 @ ___ ; ___ /10 @ ___ ; ___ /10 @ ___

Course: same / worse / improved / resolved ☐ Patient evaluated and examined by M

Level: ___1___2___3___4___5 222459 (physician #) 2278 (PA #)

Critical Care Time (excluding procedures) = ___ minutes

ED Observation Admission ED Fast Track

Consultation / Other Data Reviewed: Pt will not WB on (L) / Has access to / does not want admit
Consulted Dr. W. [illegible] 1530
Suggests: admit / discharge / will see: ✓
Case discussed with: patient / family / Radiologist / PMD
Reviewed: Nursing Home / EMS / RN / Old Records from ___

Clinical Impression (circle or write diagnoses):
right / left : ankle sprain; 5th metatarsal fracture; Jone's fracture; tibia / fibula fracture
right / left : Achilles tendon rupture; Contusion; Fracture; Laceration
(1) (L) Trimalleolar
(2) (L) ankle sprain

Medical Decision Making: L1: straightforward; L2-3: low/complex; L4: mod; L5: high
Main test ☐ if test ordered or task done; check normals ✓ abnormal and note abnormals

Lab: ☐ Lab Results Reviewed ☐ Urine / Serum preg: ___ neg pos
☐ CBC: ___ WNL ___ WNL except: ☐ Chem: ___ WNL ___ WNL except:

Wound Repair:

Location	Length / Depth	Repair
___	___ cm	suture / Dermabond / staples

superficial / SQ / IM ___ # of ___ -O (ethilon / prolene / ___)
___ # of ___ -O (vicryl / ___)
___ sensation intact ___ neurovascular intact
Level of contamination: ___ clean min / mod / severe
Anesthesia: topical / local / digital / ___ with ___ ml of:
lidocaine / marcaine / (c̄: NaHCO3 / epinephrine): 0.25% / 0.5% / 1%
☐ prep ☐ Suture / staples removal in ___ days
☐ explored: ___ no tendon injury ___ base of wound visualized ___ no foreign body
☐ irrigat. ☐ debrided ☐ undermined ☐ revised ☐ foreign body removed

Disposition: time: 1541
☐ Discharge ☒ Admit: OBS bed / general / Tele / medical / surgical / ICU
☐ Transfer: ___ to Dr. ___
Follow up: PMD / [illegible] in / on ___ days / prn / as scheduled
Condition: good / stable / serious / critical Isolation: none / droplet / contact / airborne
Restrictions: off work / limited duty / gym / school for ___
Discharge Instructions given: verbal / written / via interpreter
Discharge Rx: ibuprofen / vicodin / percocet #

[signature] MD / DO / PA Date 6/2/10
___ MD / DO / PA Date ___
[signature] MD / DO / PA Date 6/2/10

☒ Addendum: [illegible] ☐ template complete, dictation pending
See: template / dictation ☐ template complete, full / partial dictation comp
☒ See RN Notes & ED Chart ☒ template complete, no dictation needed

X21675

ED PHYSICIAN RECORD (H&P/ED)

MRN: WMH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Dillig, Cari L

FIN: 8000657116

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☐ ASLMC ☐ ASLSS ☐ AWAMC

(Addendum): Orthopedic Procedures # 63

Check ✓ if WNL, circle positives, slash negatives or negatives, mark ☐ for test ordered or tasks done

☐ **PROCEDURAL TIMEOUT:** Confirmed patient ID, reviewed procedure & equipment needs, site identified & marked.

☐ **PROCEDURAL SEDATION:** Intra-Service Time: Start time:__________ Stop time:__________

Medication: versed / fentanyl / propofol / etomidate / ketamine administered IV / IM / PO / PR / intranasal

Complications: none / vomiting / hypoxia / transient apnea /

Independent Observer: __________ RN / ED Tech / PA / MD / DO

Physician Performing Sedation: __________ MD / DO

☐ **Dislocated Joint Reduction** ☐ **Fracture Reduction** ☐ **Fracture-Dislocation Reduction** ☐ **Other:** __________

Indication: fracture / dislocated joint / vascular deficit / neurologic deficit

Location: (right / left): shoulder / arm / elbow / forearm / wrist / finger # 1 2 3 4 5
(right / left): hip / thigh / knee / lower leg / ankle / toe # 1 2 3 4 5
(right / left):

Pre-procedure Exam: ___ vascular intact ___ neuro intact ___ skin intact / __________

Anesthesia: none / procedural sedation / local / digital / regional block / hematoma block / intraarticular / __________
with ________ ml of: marcaine (0.25% / %) / lidocaine (1% / %) c̄: NaHCO3 / epinephrine

Technique: standard manual reduction / axial traction / __________
Shoulder GH reduction: traction-countertraction / Stimson technique / adduction-external rotation / scapular manipulation
Radial Head Subluxation: pronation-flexion / supination-pronation
Colles' Fracture Reduction: finger trap traction / manual traction /
Other: __________

Post-procedure Exam: ___ vascular intact ___ neuro intact ___ skin intact ___ clinically reduced, aligned ___ tolerated well

____

Post-reduction x-ray: ___ satisfactory reduction & alignment / __________
☐ Read by ED MD ☐ Radiology report reviewed by ED MD

☐ **Splint Application** ☐ **Post-Splint Neurovascular Exam** ☐ **Cast Application**

Indication: (fracture) / sprain / strain / dislocated joint / joint immobilization / laceration / __________

Splint Type: (orthoglass) / plaster / shoulder immobilizer / shoulder sling / removable wrist / finger / ankle stirrup / post-operative shoe / walking boot
(right / left): volar / dorsal / ant. / post. / shoulder immobilizer / long arm / short arm / ulna gutter / thumb spica / sugar tong / wrist
((right) / left): ant. / post. / knee immobilizer / long leg / (short leg) / ankle / sugar tong /
(right / left):

Splinted by: ED physician / (PA) / ED tech / RN

Post-splint Neurovascular Exam: ___ splint well positioned ✓ vascular intact ✓ neuro intact performed by: (PA) / ED physician

Patient Education: fracture education / joint dislocation education / splint education / crutches education / __________

☐ **Cast Removal** ☐ **Cast Bivalved** ☐ **Ring Removal** ☐ **Muscle Compartment Pressure Measurement**

Indication: pain / edema / neurological compromise / vascular compromise / ring tourniquet / potential neurovascular compromise

Location: see above / __________

Technique: Cast Removal/Cast Bivalved: oscillating cast saw / cast spreader / Webril cut / ace wrap applied / splint applied
Ring Removal: digital block with _____ ml of (1% lidocaine / 0.25% marcaine): thumb / index / middle / ring / little
surgical tube & traction / wrap compression method / ring cutter /
Compartment Pressure Measurement: Stryker System / Arterial Line System /
Compartment __________ = _____ mm Hg; Compartment __________ = _____ mm Hg
Compartment __________ = _____ mm Hg; Compartment __________ = _____ mm Hg

Complications: none / bleeding /

[signature], PA-C MD / DO / PA Physician #222782 date/time 6/2/10

[signature] MD / (DO) / PA Physician #222439 date/time 6/2/10

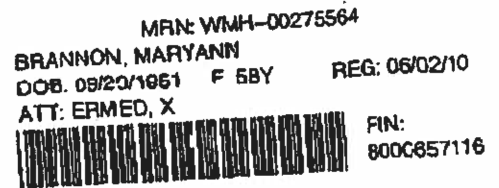
☐ template complete, dictation pending
☐ template complete, full / partial dictation comp
☒ template complete, no dictation needed

ED PHYSICIAN RECORD
(H&P/ED)

Aurora Health Care Milwaukee, Wisconsin

- [ ] ABMC
- [ ] AHCM-AS
- [ ] AHCM-SL
- [ ] AHCM-SS
- [ ] ALMC
- [ ] AMCK
- [ ] AMCMC
- [ ] AMCO
- [ ] AMCWC
- [ ] AMHB
- [ ] APH
- [ ] ASMMC
- [ ] AWAMC
- [ ] AUWAMG
- [ ] AMG (site)

MRN: WMH-00275564
BRANNON, MARYANN
DOB. 09/20/1951 F 58Y REG: 06/02/10
ATT: ERMED, X



FIN: 8000657116

I-STAT EC8+

Pt: 8000657116
Pt Name: ____________

Na	139	mmol/L
K	4.0	mmol/L
Cl	106	mmol/L
TCO2	25	mmol/L
BUN	12	mg/dL
Glu	97	mg/dL
Hct	47	%PCV
pH	7.378	
PCO2	41.0	mmHg
HCO3	24.1	mmol/L
BEecf	-1	mmol/L
AnGap	12	mmol/L
Hb*	16.0	g/dL

*via Hct

CPB: No

16:07 02JUN10

Operator ID: 00043057
Physician: ____________

Serial: 301259
Version: JAMS127A
CLEW: A18
Custom: 09C30D8L

Reference Ranges

Na	135	145	mmol/L
K	3.5	5.0	mmol/L
Cl	98	107	mmol/L
TCO2	22	30	mmol/L
BUN	10	20	mg/dL
Glu	65	99	mg/dL
Hct	36	51	%PCV
pH	7.320	7.420	
PCO2	42.0	55.0	mmHg
HCO3	23.0	29.0	mmol/L
BEecf	-2	3	mmol/L
AnGap	8	16	mmol/L
Hb*	12.0	17.0	g/dL

I-STAT Crea

Pt: 8000657116
Pt Name: ____________

Crea 0.9 mg/dL

16:07 02JUN10

Operator ID: 00043057
Physician: ____________

Serial: 334921
Version: JAMS127A
CLEW: A18
Custom: 09C30DRH

Reference Ranges

Crea 0.5 1.3 mg/dL

NORMAL RANGES FOR POINT OF CARE

Urinalysis:

Glucose = Neg

Bilirubin = Neg

Ketone = Neg

Specific Gravity = 1.005 - 1.030

Blood = Neg

pH = 5.0 - 7.0

Protein = Neg

Urobilinogen = 0 - 1.0 mg/dl

Nitrite = Neg

Leukocytes = Neg

se = 65-99 mg/dl

ionas, Yeast = None Seen

g

eg

Pregnancy Test = Pos for pregnant female

= Neg for male or non-pregnant female

05628000

LAB MOUNT SHEET
(Lab)

Aurora Health Care® Milwaukee, Wisconsin

- [ ] AHCM-AS
- [ ] AHCM-SS
- [x] AWAMC
- [ ] AMG (site)
- [ ] AHCM-SL
- [ ] AMCWC
- [ ] AUWAMG

MRN: WMH-00275564
BRANNON, MARYANN A
DOB: 09/29/1951 F 58Y
ATT: Munim, Shahida R
REG: 06/02/10
FIN: 8000657116

PERIOPERATIVE NURSING RECORD Page 1

PREOPERATIVE STATUS

Date: 6-3-10 Time: 1045

[x] Inpatient [ ] Outpatient [ ] Blood Band #

Allergies: See Allergy Report

O2 Sat. ____% [x] Room Air [ ] O2 ____ L/min

[x] IV: [ ] Capped ____ gauge [x] in place 20 gauge Rt Hand

Fluid / Site D5/0.9 Saline (300 ml left)

PREOP TUBES: [ ] Foley [ ] NG [ ] Other

Xylocaine Wheal: [ ] Yes [ ] Inserted ____ gauge ____ in by ____

Level of Consciousness: [x] Alert [ ] Lethargic [ ] Sedated [ ] Comatose [ ] Other:

Skin condition: [x] Warm [x] Dry [ ] Diaphoretic [ ] Flushing [ ] Cool [ ] Pale [ ] Jaundice [ ] Dusky

1. [x] Potential for anxiety related to:
   - [ ] Knowled deficit R/T Surgical Intervention
   - [x] Risk of death, alteration of body image or lifestyle change
   - [ ] Impaired verbal communication
   - [x] Surgical experience
   - [x] Ineffective patient/(family) coping
   - [ ] Sensory/perceptual alteration
   - [ ] Age related
   - [x] Risk for (acute)/chronic pain
   - [ ] Other:

Nursing action/Intervention:
- [x] Clear concise explanations given
- [x] Analyze/interpret preop. heath data
- [x] Support provided to patient
- [x] Support provided to (family)/ significant other
- [ ] Interpreter provided
- [x] (Assessed)/ provided pain control
- [ ] Other:

Expected outcome: [x] The patient verbalizes and/or demonstrates decreased anxiety.

[x] SHA Protocol Narrative Notes:

[x] (Patient)/ patient representative and medical record confirm (operative procedure), site mark, and site (right)/left, multiple structures, multiple levels) per policy. Ele / MP Elizabeth Jorgensen Preop RN Signature

Prophylactic IV Antibiotic: Clindamycin 900 mg Started @ 1145 by: MP

INTRAOPERATIVE STATUS

Patient Identified by: Monica Paplan RN Signature

OR #: 9	Wound Class: I	Arrival: 1113	Operation Start: 1132	Operation End: 1258	Discharge: 1300

Anesthesia: ASA 3 [x] General [ ] Regional Block [ ] Epidural [ ] Spinal [ ] MAC [ ] Local [ ] Fully monitored

Role	Name	Initials	Role	Name	Initials
Surgeon:	Dr. Sean Wilson	SW	Circulator RN:	Monica Paplan RN	MP
Assistant:	Dr. Michael Corcoran	MC	Relief:	Jodayne [illegible] RN 1210-	JC
Assistant:			Relief:		
Assistant:			Relief:		
Second Surgeon:			Scrub:	Tina Werner, ST	TW
Assistant:			Scrub:		
Assistant:			Relief:		
Anesthesiologist:	Dr. Tom Guell	TG	Relief:		
Relief:			Relief:		
Relief:			Circulator/Monitor RN:		
Anesthesia Resident:			Relief:		
Anesthesia Support/M.T.	Ellee Hazlett AA	EH	Medication RN:		
Relief:			Relief:		
Balloon Tech:			Relief:		
Laser RN/Tech:			Relief:		
Others:			Others:		

OPERATION: Open reduction - internal fixation, right ankle

2ND OPERATION:

DISCHARGE REPORT: [ ] SDS [x] PACU [ ] Pt. Room [ ] Critical Care [ ] Other

TRANSPORTED BY: [ ] Cart [ ] Wheelchair [x] Bed [ ] Mobilizer [ ] Crib [ ] Other:

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- [ ] AHCM-AS
- [ ] AHCM-SL
- [ ] AHCM-SS
- [ ] AMCWC
- [x] AWAMC
- [x] AUWAMG
- [ ] AMC (site)

MRN: WMH-00275564
BRANNON, MARYANN A
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahica R

FIN: 800065711E

PERIOPERATIVE NURSING RECORD Page 2

Date: 6/3/10

- [x] Potential for - [x] Impaired skin integrity and/or
  - [x] Pre-existing disease process
  - [x] Placement of electrical dispersive pad
  - [ ] Impaired circulation
  - [x] Positioning /impaired physical mobility
  - [x] External constriction of peripheral circulation
  - [ ] Retained foreign object
- [x] Injury related to:
  - [x] Incorrect procedure and site
  - [ ] Laser usage
  - [ ] Cell saver
  - [x] X-ray /image
  - [x] Allergic reaction
  - [x] Altered body temperature
  - [ ] Other

Nursing action/intervention: - [x] Analyze / interpret health data

- [x] Allergies status noted
- [x] Pre-procedure "Time-Out" (correct patient, procedure, accurate consent form, level, side (Right) Left), site, surgeon, patient position, radiographs, implants, and equipment, safety precautions, fluids for irrigations, prophylactic antibiotic confirmed and administered).

Time: 1120

Tourniquet # 121579 Applied by MC
(Right) Left Arm / (Leg) up 1121 down 1248 @ 300 mmHg
Right / Left Arm / Leg up ____ down ____ @ ____ mmHg
Right / Left Arm / Leg up ____ down ____ @ ____ mmHg
Right / Left Arm / Leg up ____ down ____ @ ____ mmHg

ESU#	Cut	Coag	Ground Location	By Whom:
106211	40	40	(L) thigh	myp
Bipolar #	Cut	Coag		

Other Energy Generators #

- [ ] PHACO unit # ____ Time ____
- [x] Thermia unit # 121549
- [ ] Rectal probe by ____
- [ ] SCDs thigh / knee Right / Left
- [ ] AV pulse boots Right / Left

Positioning in OR

- [x] Collaborates with health care members
- [x] Supine
- [ ] Semi-fowler
- [ ] Prone
- [ ] Knee-chest
- [ ] Eye cart
- [ ] Other
- [ ] Lithotomy
- [ ] Fowler
- [ ] Foot of bed down
- [ ] Jack-knife
- [ ] Specialty table
- [ ] Lateral Right / Left

Position Aids (Use/Location)

- [x] Safety strap
- [ ] Mummy wrap
- [x] Armboard (Right) / (Left)
- [ ] Andrew frame
- [ ] Axillary roll: Right / Left
- [ ] Ankle pillow
- [ ] Beach chair
- [ ] Chest rolls
- [ ] Cosgrove pillow
- [ ] Footboard
- [ ] Foam headrest
- [ ] Kidney rest
- [ ] Olympic Vac Pac
- [ ] Pelvic roll
- [ ] Wilson frame
- [x] Blankets warm
- [ ] Crani headrest
- [ ] Donuts
- [ ] Duval airbag
- [x] Foam Pads arms/ (L) leg
- [ ] Hip positioner
- [ ] Leg holder/stirrups/cradles Right/Left
- [ ] Overhead armboard Right/Left
- [x] Pillows head
- [x] Sand bags (R) hip
- [ ] Shoulder Traction
- [ ] Tape
- [ ] Ulnar nerve pad
- [ ] Other
- [ ] Other

Ski: Right ____ Left ____
Arms tucked: Right ____ Left ____

- [ ] Laser protocol
- [ ] Cell saver protocol
- [ ] Smoke evacuator
- [ ] Other
- [ ] Latex protocol
- [ ] Gonadal shielding
- [ ] Negative Pressure Protocol

INITIAL COUNT

	RN	Scrub
[x] Sponges	myp	TW
[x] Needles/sharps		
[ ] Instruments		

PERMANENT RELIEF COUNT

	RN	Scrub
[ ] Sponges		
[ ] Needles/sharps		
[ ] Instruments		

FINAL COUNT

	RN	Scrub
[ ] Sponges		
[ ] Needles/sharps		
[ ] Instruments		

XRAYS: - [ ] Regular flat plate - [ ] Image - [x] Fluoroscan - [x] Implant Placement - [ ] Dx - [ ] Closure

Interpreted By: ____
- [x] Surgeon - [ ] Radiologist - [ ] Anesthesiologist

Expected Outcome: - [x] The Patient's skin integrity is maintained - [x] The patient is free from injury

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☐ AHCM-AS ☐ AHCM-SS ☑ AWAMC ☐ AMG (site)
☐ AHCM-SL ☐ AMCWC ☐ AUWAMC

MRN: WMH-00275584
BRANNON, MARYANN A
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R

FIN: 800065711[illegible]

PERIOPERATIVE NURSING RECORD Page 3

Date: 6/3/10

III. ☑ Potential for infection related to:
☑ Operative procedure ☐ Wound classification ☑ Pre-existing disease process ☐ Other

Nursing action/intervention:
☑ Maintain sterile field ☑ Analyze / interpret health data
☐ Clip: Site: ______ By whom: ______
☑ Skin prep Site: Right ↓ leg & foot bed By whom: MP
☐ Chlorhexidine Gluconate ☐ Hexachlorophene
☑ Povidone Iodine spray/solution ☐ Iodophor with Alcohol
☐ Povidone Iodine soap ☐ Alcohol
☑ Chlorhexidine Gluconate with Alcohol ☐ Other: ______

Urinary catheter inserted by: ______
☐ Straight ☐ Indwelling ☐ Temp
Return: ______
Balloon filled ______ ml Size ______ Fr
☐ D/C'd in OR

Devices placed in OR:	Drain	Drain	Chest Tube	Other	Other
Size/type:					
Location:					

Dressing/packing/location: adaptic, 4x4, webril, splint

Expected Outcome: ☑ The patient's risk of infection is minimized.

IV. ☑ Potential for ineffecitve airway related to:
☐ Positioning ☑ Pre-existing disease process ☐ Surgical procedure
☑ Sedation ☑ Anesthetic agents ☐ Other: ______

Nursing action/intervention
☑ Collaborates with heathcare team members ☑ Analyze / interpret health data ☑ Monitor airway
☑ Position for adequate airway exchange ☑ Monitor oxygen saturation.
☑ Support during anesthesia ☐ Other: ______

Expected Outcome: ☑ The patient's airway is maintained.

V. Potential for hemodynamic changes related to:
☐ Electrolyte imbalance ☐ Shock / trauma ☑ Pre-existing disease
☑ Operative procedure ☐ Excessive blood loss ☐ Other ______

Nursing action/intervention
☑ Collaborates with heathcare team members. ☑ Monitor blood / fluid loss. ☑ Vital signs
☑ Analyze / interpret health data. ☐ Monitor urinary output. ☐ Other: ______

Expected Outcome: ☑ The patient's hemodynamic status is maintained.

SPECIMEN:	CULTURE:	CYTOLOGY:

Narrative Notes: Clindamycin 900 mg given @ 1145. Delayed due to multiple allergies and delay @ receiving antibiotic from pharmacy

Nursing diagnosis and care plan initiated by: Monica Papllas RN Signature

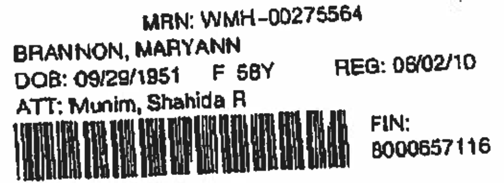
CONDITION ON DISCHARGE: ☑ See Anesthesia Record ☐ See Sedation Assessment Record

Expected Outcomes evaluated by: Monica Papllas RN Signature

Final count confirmed with Surgeon. MP / TW / SW Specimens confirmed with Surgeon. Ø

05400710

Aurora West Allis Medical Center• *Milwaukee, Wisconsin*


MRN: WMH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R
FIN: 8000657116

PRE-ANESTHESIA ASSESSMENT

Date: 6/3/10 Time: ______

Procedure: ORIF Bimalleolar fx (R)

Anesthesia History: ☑ No previous problems ______

Medical History: Height: 67" Weight: 99.5 kg ASA: III

Yes	No		Yes	No		Yes	No		Yes	No	
☑	☐	Hypertension	☑	☐	Asthma	☐	☑	Seizure	☐	☑	Diabetes
☐	☑	CAD	☑	☐	COPD	☐	☑	Hx CVA	☐	☑	Liver
☐	☑	Angina	☐	☑	URI	☐	☑	Coagulopathy	☐	☑	Kidney
☐	☑	MI	☐	☑	SOB	☐	☑	Hiatal Hernia	☐	☑	Thyroid
☐	☑	Hx CHF	☑	☐	Smoke 1½ ppd	☐	☑	GERD	☑	☐	Obesity
☐	☑	Hx Arrhythmia	☐	☑	Sleep Apnea				☐	☑	BMI > 35
☐	☑	AICD / Pacemaker									

Remarks: ______

Family History: ☑ Non-contributory ______

Current Medications: ☐ None ASA, cyclobenzaprine, codeine, darvocet, keflex, latex, nubain, advair, albuterol

Allergies: ☐ NKDA see chart

Dental: ☑ No abnormality ☐ Dentures ☐ Loose Teeth / Chips ☐ Caps ☐ Bridge

Lab: K+ - 4.0 H/H ~ 13.7/42.0

Physical Exam: Lungs: ☑ Clear Bilaterally ☐ Other:

Heart: ☑ Regular S1 and S2 without murmur ☐ Other:

Airway: ☑ MP Class I ☐ MP Class II ☐ MP Class III ☐ MP Class IV ☐ Other:

Plan:

Anesthesia Type:		Monitoring:		Post Procedure Care:		Extended Post-op Pain Control:	
General	✓	Routine	✓	Routine	✓	Epidural	
MAC		Invasive		ICU		Spinal	
Regional							

Informed Consent: ☑ Anesthesia benefits, risks and alternatives discussed with patient and/or representative. Questions answered and agreement obtained.

Comments: ______

Signature: [signature] **Date:** 6/3/10 **Time:** ______

Post-Operative Assessment:

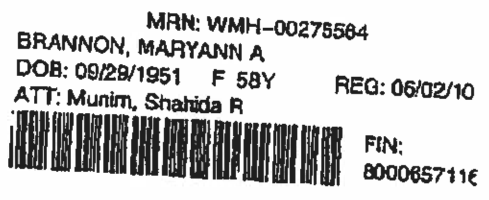
☐ Pt. awake and alert, VSS ☐ No Apparent Anesthetic Complications

Anesthesiologist: ______ **Date:** ______ **Time:** ______

X37711

Aurora Health Care• Milwaukee, Wisconsin

- [ ] ABMC
- [ ] AHCM-AS
- [ ] AHCM-SL
- [ ] AHCM-SS
- [ ] ALMC
- [ ] AMCK
- [ ] AMCMC
- [ ] AMCO
- [ ] AMCWC
- [ ] AMHB
- [ ] APH
- [ ] ASMMC
- [x] AWAMC
- [ ] AJWAMG
- [ ] AMG (site)



Date: 6/3/10

Time:

Implants/ Solutions/ Types	Location*	Size	Model	Lot /Serial /Exp /Control #	Manufacturer
	Right ankle				
Plate, 1/3 tubular x1		7 hole			Synthes
(241.371)				3 6 STERILIZED	
Screws					
Cortical		3.5			
(02.200.026) x 1					
(02.200.014) x 111					
Cancellous		4.0			
(206.018) x 1					
(206.016) x 11					

*** Document location if not specified by type of implant. Designate Right / Left if applicable.**

- [ ] Flash Sterilized with Biological Indicator

Signature: [signature]

IMPLANT RECORD

White - Medical Record / Yellow - Surgery / Pink - Inventory

Aurora Health Care® Milwaukee, Wisconsin

- [ ] ABMC
- [ ] AHCM-AS
- [ ] AHCM-SL
- [ ] AHCM-SS
- [ ] ALMC
- [ ] AMCG
- [ ] AMCK
- [ ] AMCMC
- [ ] AMCO
- [ ] AMCS
- [ ] AMCWC
- [ ] AMHB
- [ ] APH
- [ ] ASMMC
- [X] AWAMC
- [ ] AUWAMG
- [ ] AMG (site)

MRN: WMH-00275564
BRANNON, MARYANN A
DOB: 09/26/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R
FIN: 800065711

PACU Admission Date & Time: 6/3/10 @ 1300
Procedure: (R) ankle ORIF bimalleolar fx
Anesthesiologist: Guh
Type of Anesthesia: General
Allergies: Keflex, Darvocet, ASA

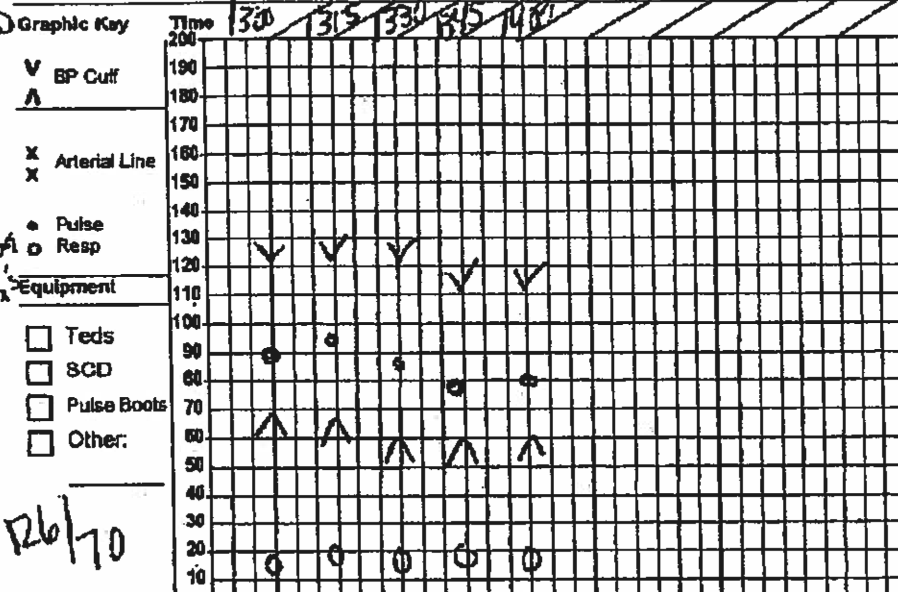
Oxygen: [ ] None [X] Tube 10 L/Min. On 1300 Off 1300 [ ] Mask ___ L/Min. On ___ Off ___ [ ] Nasal cannula ___ L/Min On ___ Off ___ [ ] Aerosol ___ % ___ L/Min On ___ Off ___ [ ] Ventilator ___ % On ___ Off ___

Airway (see key on back): LMA

Graphic Key: V BP Cuff Λ; x Arterial Line x; • Pulse; o Resp

Equipment: [ ] Teds [ ] SCD [ ] Pulse Boots [ ] Other:

126/70



Time	1300	1315	1330	1345	1400
O2 Saturation	96%	96%	94%	93%	94%
Temperature (Route)	97.4	97.3	97.3	97.4	97.1
Warming Unit/Blanket	✓	✓	✓	✓	✓
Cooling Unit/Ice					
Activity	0	2	2	2	2
Respiration	1	2	2	2	2
Circulation	2	2	2	2	2
Consciousness	0	1	1	1	1
Oxygen Saturation	1	1	1	1	2
Aldrete Total	4	8	8	8	9
Respiratory	X	✓	✓	✓	✓
Cardiac	SR	SR	SR	SR	SR
Neurovascular	✓	✓	✓	✓	✓
Spinal/Epidural					
Neurological					
G.I.		*	→	✓	✓
G.U.					
Surgical Site #1 R ankle	✓	✓	✓	✓	✓
Surgical Site #2					
Integumentary					
Musculoskeletal					
Fundus/Involuting Uterus					
R.N. Initials	KS	KS	KS	KS	KS

Report Given to: Kr
Discharged to: 306
Time: 1400
RN Signatures: [illegible]
Discharge Mode: [ ] Cart [X] Bed [ ] Wheelchair [ ] Carry

Invasive Line(s) Site: 2

INTAKE

Time	Site	Solution	ml / up	ml / left
1300	[illegible]	NS	500 T	350
1423		D5NS c 50 ml/hr		

Total IV
Total Irrigation
Total Blood / Products
Total Intake: 1750

OUTPUT

Time	Foley	Hemovac	NG	Void	Other
Total					

Total Output: Ø

MEDICATION

Time	Med	Dose	Route	Initials
1329	[illegible]	2mg	IV	KS
1330	Dilaudid	0.25	IV	KS
1337	[illegible]	2mg	IV	KS
1423	Dilaudid PCA [illegible]			KS
	See Cerner for PCA [illegible]			

PAIN MANAGEMENT

Time	Location	Quality	Scale 0-10	Intervention	Initials
1300	R foot		Ø	Ø CA9	KS
1315	R foot		Ø	CA9	KS
1330	R foot/ankle		6	CA9	KS
1337	R ankle/[illegible]		4	M / CA9	KS
1345	R ankle/ankle		3	CA9	KS
1400	R ankle/ankle		2	CA	KS

[X] Care delivered as per Protocols / Care Plans / Policies / Procedures / Standards

NOTES

1300 LMA D/C S diff. — KS
1315 C/O nausea —

97.1 117/59 80 94% RA

POST ANESTHESIA CARE UNIT PHASE 1 RECOVERY

Aurora Health Care• Milwaukee, Wisconsin

☐ AHCM-AS ☐ AHCM-SS ☐ AWAMC ☐ AMG (site)
☐ AHCM-SL ☐ AMCWC ☐ AUWAMG

MRN: WMH-00275584
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R

FIN: 800065711€

PRE-PROCEDURE FORM

NOTE: Placing your initials in the completed box means the task is completed

Date 6/3/10 Initials	Not Applicable	Pre-Procedure Checklist	Comments
SR		1. Ordered preoperative testing (within last 48 hours) completed and on chart (Lab, CXR, EKG, Blood)	
	OVE	2. Pregnancy test result in chart	
SR		3. Notify OR for (latex allergy) MSRA, Isolation, Bariatric >350 lbs. Or 159 kg) Not Allergic	
	SR	4. ☐ ICD/ Pacer present ☐ EP/Pacewatch notified day of surgery ☐ OR notified	
		5. Old records and Xrays sent to OR	
6-3-10 SR		6. Height 67" Weight ______ lbs. 99.5 kg.	
SR		7. NPO after 2359	
SR		8. History and Physical on chart (within 30 days and updated within 24 hours [day of] procedure). ● For Emergency Dept. patients: entire ED record sent	
		9. * Documentation of MD Informed Consent in chart. ● *need* Not in chart ☐ MD called	
		10. * Patient Consent form signed by patient or guardian/ activated POA ● *need*	
		11. Transfer MAR on chart	
		Complete 1-2 hours Pre-Procedure	
OVE		12. ID bands on (ID, allergy, blood band, code status)	
OVE		13. Vital Signs: T 98.5 P 92 R 16 B/P 126/70 SP O_2 97%	
	SR	14. Blood glucose (diabetics only) ______ @ (time) ______	nicotine patch on
OVE		15. Patient voided Time: 0945 ☐ Catheter in place	
SR		16. Sensory Impairment/ Barriers: ☒ Sight ☐ Hearing ☐ Speech	
		17. ☐ Language Barrier ☐ OR notified ☐ Interpretive Services Notified	
SR		18. Mental Status: ☒ Alert ☐ Sedated ☐ Unresponsive ☐ Confused	
	SR	☐ Cognitively Impaired	
	SR	19. Equipment: ☐ restraints ☐ telemetry ☐ O_2 ___ L/min	
	SR	20. Surgical site clipped	
	OVE	21. VTE Prophylaxis applied (TEDS and/or SCDs)	
	OVE	22. If patient on routine Beta-Blocker ensure dose was taken and document	
	OVE	23. Preoperative antibiotic ready to be sent to OR	
	OVE	24. Postoperative Order set on chart	
OVE		25. PERSONAL ITEMS (see below)	
OVE		26. Family waiting: ☒ Yes ☐ No Where? Surg. Waiting	

PERSONAL ITEMS	Removed	Sent		Removed	Sent
Glasses/ contact lenses	☐	☐	Jewelry/ piercings	☒	☐
Dentures/ partials/ bridge	☐	☐	Wigs/hairpins/ nail polish	☐	☐
Hearing Aids ☐ right ☐ left	☐	☐	Prosthesis	☐	☐

Valuables secured: ☐ Family/ SO ☐ Bedside/ Locker ☐ Security

Initials	Signature	Initials	Signature
SR	Stacy Raebel RN		
OVE	C. Van Epps RN		

● Mandatory for surgery to proceed

West Allis Memorial Hospital
Aurora Health Care — Milwaukee, Wisconsin

MRN: WMH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R

FIN: 8000657116

MONITORS						POSITION	
MACHINE CHECK	✓	ETCO2	✓	ART LINE		SUPINE	✓
PT IDENT / REEVAL	✓	PULSE OX	✓	CVP		PRONE	
ECG	✓	BAIR L		SWAN		LATERAL	
TEMP A E	✓	NERVE STIM.		FOLEY		LITHOTOMY	
STEH P E		BLOOD WARMER	✓	BIS		Pressure Pts. Padded	✓

Times: 11:00 — 12:00 — 13:00 — 14:00 — 15:00

AGENTS

Agent	Unit	Entries
Propofol 1% / STP 2.5%	ml	20
Fentanyl 50 mcg/ml	ml	2
Midazolam	mg	2
Lidocaine	mg	
SUCC / Rocuronium	mg	
Atracurium / Cisatracurium	mg	
Morphine / Meperidine	mg	
Remifentanil	ml	
Neostigmine	mg	
Glycopyrrolate	mg	
O2 LPM		8 0.6
N2O LPM		1.0
ISO / SEVO / DES	%	1.6

TECHNIQUE
Intravenous
Inhalation S.C.L. NRB
Spinal / Needle #
Epidural
IV BLOCK
MAC

SAT %	98 — 97 — 97 — 99 — 97 — 95 — 95 — 95
ET CO2	— 37 — 37 — 36 — 35 — 34 — 36 — 35
Temp	35.9 — 35.7 — 36.9 — 36.0
CVP	
BIS	33 — 34 — 38 — 34 — 33 — 36 — 48

Scale: 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

AIRWAY
MASK AIRWAY LMA
ET 7 7.5 8
MAC 3 4
RPD SEQ CRICOID PRS
ET 1 2 3 4 5 DIFF
CO2 + BS = LTA
LMA 2 3 4 5
Natural Airway

Eyes Taped / Lubed

FLUIDS URINE

ABX / Time:

Pre-Op Glucose:

CODE: • PULSE Λ V B.P. O RESP. ⊙ OPER X ANES

Operation: ORIF Bimalleolar fx

Anesthesiologist: Deitel Surgeon: Wilson, S.

Date: 6/3/10 Anesthesia Time From: 1115 To: 1302

REMARKS X in OR, mon pl.
① ind.

FLUID SUMMARY
Cell Saver
Cell Mass
Saline
Lact Ringers
Albumin / Hetastarch
EST. BLOOD LOSS

☑ Pacu ☑ Report Given
☐ VS Noted
☑ Meets PACU DC criteria.
May be transfered to DSC or floor

ANESTHESIA RECORD
(Procedure)

Aurora Health Care• Milwaukee, Wisconsin

☐ ABMC ☐ ALMC ☐ AMCO ☐ APH ☐ AUWAMC
☐ AHCM-AS ☐ AMCG ☐ AMCS ☐ ASMMC ☐ AMG (site) ________
☐ AHCM-SL ☐ AMCK ☐ AMCWC ☐ AWAMC
☐ AHCM-SS ☐ AMCMC ☐ AMHB

MHN: WMH-002/5564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shah'da R

FIN: 8000657118

MY INFORMED CONSENT FOR SURGERY OR OTHER PROCEDURE

Performing Provider(s): Sean Wilson

Treatment/ Procedure: Open reduction and internal fixation of right ankle fracture.

Current Condition: I understand my current medical condition, including my diagnosis and prognosis.

Treatment/ Procedure: I understand when, where, and how this Treatment/ Procedure will be done.

Risks and Benefits: I understand the risks and benefits of this Treatment/ Procedure, including the likelihood of these risks and benefits. I understand that my health care providers cannot describe every possible risk that may occur. I acknowledge that no guarantees have been made to me concerning the results of this procedure(s). In addition to the reasonable known risks of blood loss, damage to tissues, infection and cardiac arrest, the following is a list of some possible additional risks (other risks may have been discussed as noted in the physician notes or history):

- ________ - ________ - ________
- ________ - ________ - ________

Use of Anesthesia: I have received information about the use of anesthesia or sedation during this Treatment/ Procedure. I agree that if anesthesia or sedation is used, it will be provided by a qualified health care provider. He/ She will discuss the risks, benefits, and alternatives related to anesthesia or sedation with me prior to my Treatment/ Procedure.

Other Choices: I understand my other treatment options and that I could choose not to have any treatment/ procedure. I understand the risks and benefits of other Treatments/ Procedures that I could consider, and the risks and benefits if I choose not to have any Treatment/ Procedure.

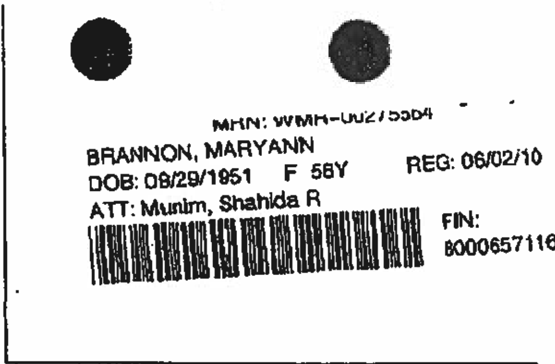
Persons Who May Participate or Observe: I understand that persons other than my Performing Provider may assist, participate or observe during my Treatment/ Procedure. A **physician, resident physician,** or other **qualified health care provider** may perform important parts of the Treatment/ Procedure. My Performing Provider will supervise all resident physicians and other qualified health care providers, but may not be physically present in the same Treatment/ Procedure room for some or all of the tasks performed by such persons. My Performing Provider will decide which physicians, resident physicians, and qualified health care providers may assist and what tasks they will perform based on my condition and the assisting providers' availability, level of competence, scope of practice, and skills. A qualified health care provider may only perform tasks for which the hospital has granted him/her privileges to perform. **Students, vendors, and other persons** may also observe or participate, but only under the express direction and supervision of the Performing Provider.

Unexpected Events: If something unexpected happens during this Treatment/ Procedure, my health care providers may decide that it is important for me to have other treatments/ procedures right away. If my health care providers decide that additional Treatments/ Procedures are in my best interests, I consent to such Treatments/ Procedures.

Use/ Disposal of Discarded Tissue. My Performing Provider may decide to use Discarded Tissue (tissue, body parts, or organs that are removed from me during this Treatment/ Procedure) for scientific, research, or teaching purposes, but will keep my identity confidential. I agree to such use.

Aurora Health Care• Milwaukee, Wisconsin

- [ ] ABMC
- [ ] AHCM-AS
- [ ] AHCM-SL
- [ ] AHCM-SS
- [ ] ALMC
- [ ] AMCG
- [ ] AMCK
- [ ] AMCMC
- [ ] AMCO
- [ ] AMCS
- [ ] AMCWC
- [ ] AMHB
- [ ] APH
- [ ] ASMMC
- [ ] AWAMC
- [ ] AUWAMG
- [ ] AMG (site) ______



MRN: WMH-00275564
BRANNON, MARYANN
DOB: 08/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R
FIN: 8000657116

Do-Not-Resuscitate (DNR) Orders: If I have a DNR order, my Performing Provider and I have discussed how my DNR order will be managed. I agree that my DNR order *(check one)*:

- [ ] will continue as stated in my DNR order
- [ ] will be modified as follows: ______
- [ ] will be suspended during the Treatment/ Procedure and until I am transferred from the recovery room to the patient care area.

Use of Implanted Tissue/ Devices: Transplanted tissue, organs, bone/ tissue grafts, devices and/ or other instrumentation that will remain in or with me as a result of this Treatment/ Procedure is called an "Implant." I agree that the following Implants may be used and that during the Treatment/ Procedure my Performing Provider may decide that other Implants may be necessary.

Transfusion of Blood/ Blood Products: I understand that if my health care providers decide that I need blood or blood products during my Treatment/ Procedure, I will receive blood or blood products through my vein(s). I understand that a blood transfusion may expose me to certain illnesses, such as HIV and Hepatitis B or C, but that the presence of these viruses in blood/ blood products is extremely rare. I also understand that transfusion of the wrong blood type can be fatal, but that this is also very rare. Other risks that can occur with blood/ blood products include bruising, swelling, fever, headache, and local infection where the needle pierces the skin. I understand the alternatives to blood transfusion and the consequences of non-treatment.

- [ ] **I refuse Blood or Blood Products**

Limitations on Confidentiality: I understand that in some circumstances my health care providers may be required to share information about me with others. For example, if I have a communicable illness, my health care provider, or the clinic/ hospital may be required by law to inform the public health department.

Withdrawal of Consent: I understand that I can withdraw my consent to have this Treatment/ Procedure at any time before the Treatment/ Procedure is started.

Time Limit: This Informed Consent Form is only effective for sixty (60) days after I sign it, unless otherwise noted here: ______

Other Information: ______

PATIENT / REPRESENTATIVE SIGNATURE: I read and understand the information on this form and all the information that has been provided to me about this Treatment/ Procedure. I do not have any unanswered questions and I want to proceed with this Treatment/ Procedure.

x Mary A Brannon | ______ | 6-3-10 | 1057
Patient/ Representative Signature or Telephone Consent from | Relationship to Patient | Date | Time

______ | ______ | ______
Witness (Only if Telephone Consent) | Date | Time

Interpreter Assistance: If an interpreter assisted, please complete the following:

Signature: ______ **Date:** ______ **Time:** ______

Practitioner Documentation of Informed Consent Discussion: I discussed the information described above (as applicable) and other relevant information with this Patient/ Representative, prior to requesting that this Patient/ Representative review and complete this *Informed Consent Form*. This Patient/ Representative denied unanswered questions and consented to this Treatment/ Procedure.

Practitioner Signature: [signature] Date: 6/3/10 Time: 1057

* 5 3 6 4 6 9 *

INFORMED CONSENT
(Consent)

Aurora Health Care® Milwaukee, Wisconsin

☐ AHCM-AS ☐ AMCK ☐ AMHB ☐ AMG (site) ______
☐ AHCM-SL ☐ AMCMC ☐ APH
☐ AHCM-SS ☐ AMCO ☐ ASMMC
☐ ALMC ☐ AMCWC ☐ AWAMC

MRN: WMH-00275564
BRANNON, MARYANN
DOB: 09/29/1951 F 58Y REG: 06/02/10
ATT: Munim, Shahida R
FIN: 8000657116

MEDICATIONS:

☒ See Medication List **(bring to your doctor appointments)**

☐ Other: ______

Prescriptions called to: ______

VACCINES:

Your influenza vaccine was given on ______

Your pneumonia vaccine was given on ______

☐ Follow-up with your doctor regarding influenza and/ or pneumonia vaccine(s)

ACTIVITY:

☒ ~~Weigh yourself daily (first thing in the morning, with same amount of clothes on) unless told otherwise by your doctor~~

☒ Continue activity as you were in the hospital, slowly increase to what you were doing previously

☐ Up as desired / no restrictions

☐ Check with your doctor if able to go to work/ school

☐ Other: ______

SMOKING:

☒ Avoid all tobacco products and second hand smoke

☐ Smoking Cessation Counseling offered
Wisconsin Toll Free Quit Line: 1-877-270-7867

DIET:

☒ Limit salt (sodium) and salty foods unless told otherwise by your doctor.

☐ No Restrictions

☐ Special Diet ______

☐ Other ______

☒ **Call 911 if you have trouble breathing or chest pain.**

CALL YOUR DOCTOR IF:

☐ You have symptoms that are not "normal" for you

☒ You have new or worse symptoms or pain, not relieved by medicine or rest

☒ Temperature greater than 101°F, chills or flu like symptoms

☐ You gain more than 3 pounds in 2 days

☐ Increased swelling, redness or drainage

☐ Other: ______

REFERRALS (Type/ Agency/ Phone):

☐ Home Health ______

☐ Community Services ______

☐ Telemanagement: **1-888-676-7812**

☐ Other ______

FOLLOW-UP (Call for appointment if not scheduled):

Follow-up appointment with:
Dr. Sean Wilson
Tel (414) 328-6000 When Next week

Follow-up appointment with:
Dr. ______
Tel (____) ______ When ______

Additional instructions: Wear cam boot on left leg at all times - sponge bathe until follow up w/ Dr. & Non-weight bearing on Right leg

This form was reviewed with patient / responsible person by: Both ______ Date/Time: ______ / ______

Final Discharge (date/time) 6/4/10 / 1548 Method: Self Discharged to: Home
With whom: Husband Nurse Signature: [signature]

DISCHARGE INSTRUCTIONS-GENERAL
(Edu / D/C Plan)

White Original – Medical Record
White Copy - Patient
© AHC 05100940 (Rev. 05/09)

Aurora Health Care®

CERTIFICATION OF MEDICAL BILLING RECORDS

Patient Name: MARY ANN BRANNON

I certify that the documents attached to this certificate, consisting of 4 pages, are accurate, legible, and complete duplicates of the original billing records of the patient listed above for the following time period:

To: 6/2/2010 to 6/4/2010

Exclusions:

☑ None

☐ As follows:

I further certify that the original records were: (1) made at or near the time of the occurance of the matters set forth by, or information transmitted by, a person with knowledge of those matters; (2) kept in the course of regular conducted activity; and (3) made by the regulary conducted activity as a regular practice.

I certify under penalty of perjury under the laws of the United States of America that the foregone is true and correct.

Executed on this 2nd day of November, 2011.

Susan Claussen

Susan Claussen
Manager, Patient Accounts
Aurora Health Care Business Office

For questions on this account, contact Customer Service at (866) 244-0821, Monday-Friday 8:30-4:30

Patient Name: MARY ANN BRANNON

Account Number 000275564

WJ **Office Use: Please apply to account number 505/2008/770000**

AURORA HEALTH CARE
AURORA WEST ALLIS MEDICAL CENTER
PATIENT ACCOUNT - DETAIL

PATIENT NAME: BRANNON, MARYANN A

ACCOUNT NBR: 000275564-0153
BILLING PERIOD: 06/02/10 11/02/11

BILL TO
MARYANN A BRANNON
APT 109
2092 S 102ND ST
WEST ALLIS WI 532271317
USA

SRV DATE	REF NBR	DESCRIPTION		
06/02/10	37200000	STANDARD ROOM		1410.00
06/02/10	87900300	ANKLE COMPLETE BILATERAL	(QTY OF 0000001)	571.00
06/02/10	88051500	COUNTER-PORTABLE	(QTY OF 0000001)	0.00
06/02/10	87885800	CHEST 1 VIEW	(QTY OF 0000001)	142.25
06/02/10	20044551	CBC W/AUTO DIFF	(QTY OF 0000001)	61.25
06/02/10	20046261	PROTHROMBIN TIME	(QTY OF 0000001)	78.25
06/02/10	20047681	PARTIAL THROMBOPLASTIN TIME	(QTY OF 0000001)	77.75
06/02/10	92744991	POC CREATININE	(QTY OF 0000001)	50.50
06/02/10	92759341	POC CHLORIDE SERUM	(QTY OF 0000001)	62.50
06/02/10	92744983	POC BLOOD GASES	(QTY OF 0000001)	91.00
06/02/10	92744999	POC GLUCOSE SERUM	(QTY OF 0000001)	54.75
06/02/10	92745011	POC POTASSIUM SERUM	(QTY OF 0000001)	54.25
06/02/10	92745019	POC SODIUM SERUM	(QTY OF 0000001)	20.00
06/02/10	92745007	POC NITROGEN SERUM	(QTY OF 0000001)	65.75
06/02/10	92745003	POC HEMATOCRIT	(QTY OF 0000001)	30.75
06/02/10	92746428	ECG TRACING ONLY	(QTY OF 0000001)	144.00
06/02/10	92766457	ED LEVEL 5 TYPE B VISIT	(QTY OF 0000001)	1560.75
06/02/10	92743208	INHALATION TX HHN INITIAL	(QTY OF 0000001)	163.00
06/02/10	92743218	INHALATION TX MDI INITIAL	(QTY OF 0000001)	93.50
06/02/10	92743229	PULSE OXIMETRY SINGLE	(QTY OF 0000001)	82.25
06/03/10	37200000	STANDARD ROOM		1410.00
06/02/10	15800250	MORPHINE INJ 10 MG/M	(QTY OF 0000001)	53.30
06/02/10	15800250	MORPHINE INJ 4 MG/ML	(QTY OF 0000001)	51.09
06/02/10	15800150	BULK MEDICATION	FLUTICASONE/SALMETER	397.72
06/02/10	15800010	UNIT DOSE	MONTELUKAST CHEW 5 M	24.15
06/02/10	15800010	UNIT DOSE	NICOTINE PATCH 14 MG	16.02
06/02/10	15800080	IV SOLUTIONS	DEXTROSE 5% / NACL 0	75.38
06/02/10	15800250	MORPHINE INJ 2 MG/ML	(QTY OF 0000001)	53.87
06/02/10	15800250	PANTOPRAZOLE INJ 40	(QTY OF 0000001)	41.41
06/02/10	15800010	UNIT DOSE	SENNOSIDES CONC 8.6	5.92
06/02/10	15800010	UNIT DOSE	ALBUTEROL/IPRATROPIU	7.11
06/02/10	15800010	UNIT DOSE	MONTELUKAST CHEW 5 M	24.15
06/02/10	15800010	UNIT DOSE	NICOTINE PATCH 14 MG	16.02
06/02/10	15800250	PANTOPRAZOLE INJ 40	(QTY OF 0000001)	41.41
06/02/10	15800010	UNIT DOSE	VITAMIN - THERAPEUTI	6.43
06/02/10	15800010	UNIT DOSE	SENNOSIDES CONC 8.6	17.77
06/03/10	20044551	CBC W/AUTO DIFF	(QTY OF 0000001)	61.25
06/03/10	20048511	COMPREHENSIVE METABOLIC PANEL	(QTY OF 0000001)	201.50
06/03/10	20207461	VENIPUNCTURE	(QTY OF 0000001)	20.00
06/03/10	92754693	ANESTH GENERAL 1ST 1/2 HR	(QTY OF 0000001)	2446.00
06/03/10	92754698	ANESTH GENERAL ADD'L 30 MIN	(QTY OF 0000003)	444.75

PATIENT NAME: BRANNON, MARYANN A ACCOUNT NBR: 000275564-0153

SRV DATE	REF NBR	DESCRIPTION		
06/03/10	92755234	ECG INTERPRETATION/REPORT	(QTY OF 0000001)	19.75
06/03/10	68640517	ANCHOR/SCREW BONE/TISSUE	PLATE	1785.00
06/03/10	68640517	ANCHOR/SCREW BONE/TISSUE	CORTEX SCREW	1328.00
06/03/10	68640517	ANCHOR/SCREW BONE/TISSUE	BONE SCREW	657.00
06/03/10	63639270	MAXI SURGIKIT DISP	(QTY OF 0000001)	257.00
06/03/10	68640430	EXTREMITY DRAPE	(QTY OF 0000001)	147.25
06/03/10	63637910	SPLIT SHEET DISP	(QTY OF 0000002)	317.00
06/03/10	63631560	TOURNIQUET/STERILE CUFF DISP	(QTY OF 0000001)	275.75
06/03/10	63637760	SPLINT ORTHOGLASS DISP	(QTY OF 0000001)	168.50
06/03/10	63635070	OPERATING ROOM A TO 2 HOURS	(QTY OF 0000001)	5142.00
06/03/10	92743209	INHALATION TX HHN SUBS	(QTY OF 0000001)	120.50
06/03/10	92743209	INHALATION TX HHN SUBS	(QTY OF 0000001)	120.50
06/03/10	92743219	INHALATION TX MDI SUBS	(QTY OF 0000001)	35.25
06/03/10	92737892	COUNTER-THERAPY VISIT/PT	(QTY OF 0000001)	0.00
06/03/10	92742165	PHYSICAL THERAPY EVAL	(QTY OF 0000001)	267.75
06/03/10	92737902	THERAP ACTIVITIES PT PER 15MIN	(QTY OF 0000003)	369.75
06/03/10	73733070	BLADDER SCAN-RESIDUAL URINE	(QTY OF 0000001)	148.00
06/03/10	15800250	CLINDAMYCIN INJ 150	(QTY OF 0000006)	38.16
06/03/10	15800250	CLINDAMYCIN INJ 150	(QTY OF 0000012)	76.33
06/03/10	15800250	MORPHINE INJ 2 MG/ML	(QTY OF 0000001)	53.87
06/03/10	15800010	UNIT DOSE	ALBUTEROL/IPRATROPIU	7.11
06/03/10	15800250	MORPHINE INJ 2 MG/ML	(QTY OF 0000001)	53.87
06/03/10	15800250	ROPIVACAINE INJ 0.5%	(QTY OF 0000150)	66.15
06/03/10	15800250	MIDAZOLAM INJ 1 MG/M	(QTY OF 0000002)	51.54
06/03/10	15800250	FENTANYL INJ 50 MCG/	(QTY OF 0000001)	51.03
06/03/10	15800310	SMALL VOLUME PARENTERAL	SODIUM CHLORIDE 0.9%	75.33
06/03/10	15800010	UNIT DOSE	ALBUTEROL/IPRATROPIU	7.11
06/03/10	15800250	HYDROMORPHONE PCA 0.	(QTY OF 0000003)	105.95
06/03/10	15800080	IV SOLUTIONS	DEXTROSE 5% / NACL 0	75.38
06/03/10	15800250	DROPERIDOL INJ 2.5 M	(QTY OF 0000001)	27.00
06/03/10	15800250	ONDANSETRON INJ 2 MG	(QTY OF 0000004)	25.77
06/03/10	15800250	MORPHINE INJ 10 MG/M	(QTY OF 0000001)	53.30
06/03/10	15800250	ENOXAPARIN INJ 40 MG	(QTY OF 0000004)	123.61
06/03/10	15800010	UNIT DOSE	MONTELUKAST CHEW 5 M	24.15
06/03/10	15800010	UNIT DOSE	NICOTINE PATCH 14 MG	16.02
06/03/10	15800250	PANTOPRAZOLE INJ 40	(QTY OF 0000001)	41.41
06/03/10	15800010	UNIT DOSE	VITAMIN - THERAPEUTI	6.43
06/03/10	15800310	SMALL VOLUME PARENTERAL	SODIUM CHLORIDE 0.9%	150.67
06/03/10	15800040	CONTROLLED SUBSTANCE SCH II	OXYCODONE/APAP 5-325	13.45
06/03/10	15800300	CONTROLLED SUBSTANCE SCH II	HYDROCODONE/APAP 5-3	13.53
06/03/10	15800010	UNIT DOSE	SENNOSIDES CONC 8.6	17.77
06/03/10	92753017	PACU LEVEL 3, 1ST 30 MIN	(QTY OF 0000001)	801.75
06/03/10	92753019	PACU LEVEL 2 EA ADD'L 30 MIN	(QTY OF 0000001)	151.75
06/04/10	92737892	COUNTER-THERAPY VISIT/PT	(QTY OF 0000001)	0.00
06/04/10	92737902	THERAP ACTIVITIES PT PER 15MIN	(QTY OF 0000003)	369.75
06/04/10	92737939	COUNTER-THERAPY VISIT OT	(QTY OF 0000001)	0.00
06/04/10	92742167	OCCUPATIONAL THERAPY EVAL	(QTY OF 0000001)	221.25
06/04/10	92737944	ADL/SELF CARE OT PER 15 MIN	(QTY OF 0000003)	351.75
06/04/10	92737892	COUNTER-THERAPY VISIT/PT	(QTY OF 0000001)	0.00
06/04/10	92737902	THERAP ACTIVITIES PT PER 15MIN	(QTY OF 0000002)	246.50

PATIENT NAME: BRANNON, MARYANN A   ACCOUNT NBR: 000275564-0153

SRV DATE	REF NBR	DESCRIPTION		
06/04/10	15800250	DIPHENHYDRAMINE INJ	(QTY OF 0000001)	26.55
06/04/10	15800040	CONTROLLED SUBSTANCE SCH II	OXYCODONE/APAP 5-325	13.45
06/04/10	15800040	CONTROLLED SUBSTANCE SCH II	OXYCODONE/APAP 5-325	13.45
06/04/10	15800040	CONTROLLED SUBSTANCE SCH II	OXYCODONE/APAP 5-325	13.45
06/04/10	15800040	CONTROLLED SUBSTANCE SCH II	OXYCODONE/APAP 5-325	13.45
06/04/10	15800250	PROPOFOL INJ 10 MG/M	(QTY OF 0000020)	74.62
06/04/10	15800250	FENTANYL INJ 50 MCG/	(QTY OF 0000001)	51.03
06/04/10	15800250	MIDAZOLAM PF INJ 1 M	(QTY OF 0000002)	50.61
06/04/10	15800150	BULK MEDICATION	SEVOFLURANE INHALATI	286.20
06/02/10	92744861	IV PUSH 1ST OR SINGLE DRUG	(QTY OF 0000001)	63.00
06/02/10	92745178	VENIPUNCTURE	(QTY OF 0000001)	20.50
06/02/10	92744736	APPLY SPLINT SHORT LEG	(QTY OF 0000001)	612.25
06/02/10	92759355	ACE BANDAGE 3-5IN/EA YARD	(QTY OF 0000005)	13.75
		-- WE HAVE BILLED THE FOLLOWING INSURANCE(S) --		
		MEDICARE PART A	06/02/10 - 06/24/10	
		MEDICARE PRO COMP	06/02/10 - 06/24/10	
		T19 STANDARD	06/02/10 - 06/24/10	
06/09/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/02/10	17798.11
06/24/10	00004709	MEDICARE ADJUSTMENT MEDICARE PART A	SERVICE ON 06/02/10	0.25
06/24/10	00006909	MEDICARE PAYMENT MEDICARE PART A	SERVICE ON 06/02/10	6330.64
07/01/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/04/10	709.50
07/06/10	00006959	MEDICARE PAYMENT REVERSAL MEDICARE PART A	SERVICE ON 06/02/10	0.00
07/07/10	00004709	MEDICARE ADJUSTMENT MEDICARE PRO COMP	SERVICE ON 06/03/10	10.85
07/07/10	00006909	MEDICARE PAYMENT MEDICARE PRO COMP	SERVICE ON 06/03/10	7.12
07/08/10	00004709	MEDICARE ADJUSTMENT MEDICARE PART A	SERVICE ON 06/02/10	709.25
07/08/10	00006909	MEDICARE PAYMENT MEDICARE PART A	SERVICE ON 06/02/10	6330.64
07/08/10	00006959	MEDICARE PAYMENT REVERSAL MEDICARE PART A	SERVICE ON 06/02/10	6330.64
07/13/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/02/10	709.50
07/13/10	00004709	MEDICARE ADJUSTMENT MEDICARE PART A	SERVICE ON 06/02/10	0.25
07/13/10	00006909	MEDICARE PAYMENT MEDICARE PART A	SERVICE ON 06/02/10	0.00
07/13/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/02/10	709.50
06/09/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/02/10	17798.11
07/01/10	00059100	MEDICARE PART A DRG ADJUSTME MEDICARE PART A	SERVICE ON 06/04/10	709.50
07/23/10	00059100	MEDICARE PART A DRG ADJUSTME	SERVICE ON 06/02/10	18507.61

PATIENT NAME: BRANNON, MARYANN A   ACCOUNT NBR: 000275564-0153

SRV DATE	REF NBR	DESCRIPTION		
		MEDICARE PART A		
07/26/10	00059100	MEDICARE PART A DRG ADJUSTME	SERVICE ON 06/02/10	17798.11-
		MEDICARE PART A		
07/26/10	00059100	MEDICARE PART A DRG ADJUSTME	SERVICE ON 06/02/10	18507.61
		MEDICARE PART A		
07/26/10	00006909	MEDICARE PAYMENT	SERVICE ON 06/02/10	0.00
		MEDICARE PART A		
08/20/10	00004715	MEDICAID ADJUSTMENT	SERVICE ON 06/02/10	1.78-
		T19 STANDARD		
10/22/10	00006915	MEDICAID PAYMENT	SERVICE ON 06/02/10	1100.00-
		T19 STANDARD		

REMIT TO
AURORA WEST ALLIS MED CTR
PO BOX 341100
MILWAUKEE WI 532341100

BEGINNING BALANCE	0.00
NEW CHARGES/ADJUSTMENTS	70013.36
NEW PAYMENTS/CREDITS	70013.36
CURRENT ACCOUNT BALANCE	0.00

MAKE CHECK PAYABLE TO: AURORA WEST ALLIS MED CTR

IF YOU HAVE ANY QUESTIONS CONCERNING THIS ACCOUNT PLEASE CONTACT:
AURORA HEALTH CARE   PHONE: (800) 958-6202

ACCOUNT NUMBER 840*0028322751

DATE OF STATEMENT 08/20/2010

PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT

BALANCE

AMOUNT DUE $36.43

PATIENT NAME

MARYANN A BRANNON

BILLING QUESTIONS
OUT OF AREA: 1(866)-898-7139 CUSTOMER SERVICE
MON-FRI 8:30 AM THRU 5:00 PM EST
Por Assistencia en Espanol Llama Al Numero Ariba.

****
FINAL NOTICE TO AVOID FURTHER COLLECTION ACTION THIS ACCOUNT MUST BE PAID IMMEDIATELY.
****

Tax Id 391499986
Place of Service: WEST ALLIS MEMORIAL HOSPITAL

MAKE CHECKS PAYABLE TO:

ERMED SC
PO BOX 78012
MILWAUKEE WI 53278-0012
(866)-898-7139

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

Page 1

Date	Doctor	Code	Description	Amou
06/02/2010	CARI L DILLIG, PA	9928525	EMERGENCY DEPARTMENT VISIT	663.0
06/02/2010	CARI L DILLIG PA	29515	SHORT LEG SPLINT CALF TO FOOT	249.0
07/14/2010		0030036	PAYMENT - INS#1	-114.8
07/14/2010		0030036	WRITE OFF - INS#1	-519.3
07/14/2010		0030036	PAYMENT - INS#1	-30.8
07/14/2010		0030036	WRITE OFF - INS#1	-210.4

KELLY SMITH DO CARI L DILLIG PA

ACCESS/CHANGE YOUR ACCOUNT VIA THE INTERNET ANYTIME!!!
Visit us at http://www.peryourhealth.com and enter your account number of 840-28322751 and password E11558

PLEASE DETACH AND RETURN THE BOTTOM PORTION WITH PAYMENT

840*0028322751
ERMED SC
P.O. BOX 808
GRAND RAPIDS MI 49518-0808

Return Service Requested

ACCOUNT NUMBER 840*0028322751

PATIENT NAME MARYANN A BRANNO

STATEMENT DATE 08/20/2010

AMOUNT DUE $36.43

AMOUNT ENC

MasterCard VISA DISCOVER

To make credit card payments:
www.peryourhealth.com (see statement detail for account number and password) or call (866)-898-7139

GOT501.A3HWQ8001693.J05UOJ.004689 004685

MARYANN A BRANNON
2092 S 102ND ST APT 109
MILWAUKEE WI 53227 - 1317

685

MAKE CHECKS PAYABLE AND REMIT TO:

ERMED SC
PO BOX 78012
MILWAUKEE WI 53278-0012

23641

Diagnostic Mobile Imaging LLC
N4 W22540 Bluemound Road · Waukesha, WI 53186
Phone: (262) 544-9825 · Fax: (262) 544-9827

X-Ray Requisition Form

(Please Print) 44425 R-17

PATIENT'S NAME: BRANNON, MARYANN DOB: 9-25-51 DATE: 8-3-10
N.H./RESIDENCE: 2092 S 102ND ST. ROOM # 109 PHONE:
PERSON PLACING ORDER: KIM AGENCY: GENTIVA FAX 425
PHYSICIAN: CHANG, STEVE PHONE: 0696

TYPE OF X-RAY: CXR

x ______________________

HHS REQUIRES PHYSICIAN'S SIGNATURE
requesting exam, certifying reason, No. of views, and that the patient is considered 'homebound.'

12

Dx/SYMPTOM: CONGESTION
Please do not use Rule Out as reason for X-ray

FORWARD

MEDICARE #: 394 58 4069A TITLE19 #: 741 804 2671
OTHER INS.: ADDRESS:
GROUP #: POLICY:
RESPONSIBLE PARTY:
ADDRESS: PHONE:

[ ] 71010 CHEST AP
[✓] 71020 CHEST AP & LATERAL
[R][L] [ ] 71100 RIBS Unilateral 2 views
[ ] 71110 RIBS Bilateral, 3 views
[ ] 72170 PELVIS AP
[R][L] [ ] 73510 HIP Unilateral 2 views
[ ] 73520 HIPS Bilateral
[R][L] [ ] 73550 FEMUR 2 views
[R][L] [ ] 73560 KNEE 2 views
[R][L] [ ] 73590 TIBIA & FIBULA 2 views
[R][L] [ ] 73610 ANKLE 3 views
[R][L] [ ] 73600 ANKLE 2 views
[R][L] [ ] 73630 FOOT 3 views
[R][L] [ ] 73620 FOOT 2 views
[R][L] [ ] 73030 SHOULDER 2 views
[R][L] [ ] 73000 CLAVICLE 2 views
[R][L] [ ] 73010 SCAPULA

[R][L] [ ] 73060 HUMERUS 2 views
[R][L] [ ] 73070 ELBOW 2 views
[R][L] [ ] 73090 FOREARM 2 views
[R][L] [ ] 73110 WRIST 3 views
[R][L] [ ] 73100 WRIST 2 views
[R][L] [ ] 73130 HAND 3 views
[R][L] [ ] 73120 HAND 2 views
[ ] 70250 SKULL 3 views
[ ] 70210 SINUSES 2 views
[ ] 70140 FACIAL BONES 2 views
[ ] 74000 ABDOMEN (KUB) 1 view
[ ] 74020 ABDOMEN SERIES 2 views
[ ] 72040 CERVICAL SPINE 2 views
[ ] 72070 THORACIC SPINE 2 views
[ ] 72100 LUMBAR SPINE 2 views
[ ] 72220 SACRUM & COCCYX 2 v

TECH: GL CALLED BY: CALLED TO: TIME CALLED: FAX:
RADIOLOGIST: KWOCK TRANS CODE: / SET UP CODE: / DIAG. CODE:

23641

DIAGNOSTIC MOBILE IMAGING LLC
N4 W22540 Bluemound Road
Waukesha, WI 53186
(262) 544-9825 FAX (262) 544-9827

RADIOLOGY REPORT

NAME: Brannon, MaryAnn *RM#: Apt 109* *DATE: 08-03-2010*

RESIDENCE: 2092 S. 102nd Street *DOB: 9-29-51* *DR: Chang*

EXAMINATION: AP & Lateral Chest

X-RAY #: 23641 *TECH: GL* *ISM*

AP & Lateral Chest

Indications: Congestion

No comparison films. Heart size and pulmonary vascularity are within normal limits. No infiltrates or pleural effusions are seen. Lungs are mildly hyperinflated. Minimal degenerative spurring of the thoracic spine is seen.

IMPRESSION: No radiographic findings for acute pulmonary disease.

L. KWOCK, M.D.
LK/lmm

71020

Statement

Diagnostic Mobile Imaging LLC
N4 W22540 Bluemound Road
Waukesha, WI 53186
262-544-9825

Date
1/12/2011

To:
Maryann Brannon 2092 S. 102nd Milwaukee, WI PATIENT: MARYANN BRANNON

Amount Due	Amount Enc.
$9.00	

Date	Transaction	Amount	Balance
07/31/2010	Balance forward		0.00
08/03/2010	AP & Lateral Chest Xray	258.00	258.00
09/27/2010	PMT Medicare	-142.37	115.63
09/27/2010	Discount Medicare	-80.04	35.59
10/01/2010	PMT	-2.93	32.66
10/01/2010	Discount	-23.66	9.00

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
9.00	0.00	0.00	0.00	0.00	$9.00

225 S. Executive Drive
Brookfield,WI 53005-4257
(262) 787-6700

CERTIFICATION OF ITEMIZED STATEMENTS

I, Allie Halliwell, the undersigned, Patient Billing Custodian of Milwaukee Anesthesia Consultants, do here certify that the enclosed pages are itemized statements for our patient, Maryann Brannon, for services between the dates of 6/03/10 and 6/03/10.

Dated this the 15th day of January 2011.

Allie Halliwell
Patient Billing Custodian

225 S. Executive Drive
Brookfield, WI 53005-4257
(262) 787-6700

Itemized Statement

Provider: Milwaukee Anes. Consultants

Remittance Address: 225 S. Executive Dr, Brookfield, WI 53005

Tax ID#: 39-1803787

Telephone: 262-787-4026

Statement Prepared By: AH Date: 1/15/11

Patient: Maryann Brannon

Social Security #: 394-58-4069

Date Of Birth: 9/29/51

Account #	Date of Service	Billed Amount	Work Comp Payments		Health Ins Payments	Write-offs	Patient Payments	Remaining Balance
222-208-57343-0	6/03/10	207.65		Forward HH 41.53	Medicare 166.12			0.00

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | | PICA | CARRIER

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 394584069A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brannon, Maryann

3. PATIENT'S BIRTH DATE MM DD YY: 09 29 1951 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Brannon, Maryann

5. PATIENT'S ADDRESS (No., Street): 2092 S 102nd St #109

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 2092 S 102nd St #109

CITY: West Allis STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: West Allis STATE: WI

ZIP CODE: 53227 TELEPHONE (Include Area Code): ( )

ZIP CODE: 53227 TELEPHONE (Include Area Code): (414) 731-1563

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Brannon, Maryann

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: Medigap 3945840690

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature on File.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File.

SIGNED ______

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 02 10 TO STILL

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 824.8
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 03 10	06 03 10	21	N	01480	AA	1	207 65	109		NPI	1871576413
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1803787 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 222-208573430

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 207 65

29. AMOUNT PAID: $

30. BALANCE DUE: $ 0 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Thomas J Guhl M.D.
SIGNED 01/15/2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION
West Allis Memorial Hospit
8901 W. Lincoln Avenue
West Allis, WI 53227-2409
a. 1407801640 b.

33. BILLING PROVIDER INFO & PH # ( )
Milwaukee Anes Consultants Lt
Bin 88845
Milwaukee WI 53288-0001
a. 1902852098 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-0

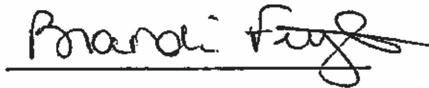
M1 N 3 HH/EILLA Telephone (262) 787-6700

Certification Of Billing Records

Patient Name. Mary Brannon
Date of Birth. 09/29/1951
Date of Injury. 6/2/2010

I, Brandi Fryt, custodian of medical and billing records at Internal Medicine Associates in West Allis, Wisconsin, hereby certify that the documents annexed hereto, and consisting of 3 pages constitute an accurate, legible and complete duplicate of the records regarding our patient, Mary Brannon, for the dates of service 6/2/2010 to 1/13/2011.

Dated at West Allis, Wisconsin, this 13th day of January 2011



Signature

Internal Medicine Associates
7200 W. Greenfield Avenue
Phone (414)543-1441
Fax (414)543-1521
Billing/Records (414)543-1348

INTERNAL MEDICINE ASSOCIATES

7200 W GREENFIELD AVENUE
WEST ALLIS, WI 53214
(414)543-1441

1/13/2011

Patient: Mary A. Brannon
2092 S 102nd Street
Milwaukee, WI 53227-1317

Chart #: BRAMA001

Case #: 16346

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charg
6/2/2010	Initial Inpatient Admission Level 3	99223	AI	824.6	E888.9			1	348.9
7/12/2010	Medicare Deductible	MEDDED						1	0.0

Provider Information

Provider Name: Masroor Munim MD
License: 37915
Medicare PIN:
SSN or EIN: 392011386

Total Charges:	$ 348
Total Payments:	$ 0
Total Adjustments:	$ 0
Total Due This Visit:	**$ 348.**
Total Account Balance:	$ 413

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: ____________________ Date: __________

INTERNAL MEDICINE ASSOCIATES

7200 W GREENFIELD AVENUE
WEST ALLIS, WI 53214
(414)543-1441

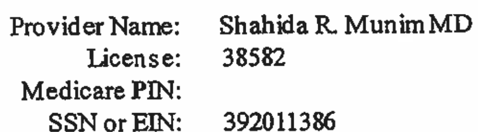
1/13/2011

Patient: Mary A. Brannon
2092 S 102nd Street
Milwaukee, WI 53227-1317

Chart #: BRAMA001
Case #: 16347

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
6/3/2010	Inpatient Follow-Up Level 3	99233	AI	824.6	E888.9			1	181.8
6/4/2010	Hospital Discharge >30 minutes	99239	AI	824.6	E888.9			1	182.1
7/12/2010	Medicare Deductible	MEDDED						1	0.0
7/12/2010	Medicare Deductible	MEDDED						1	0.0



Provider Information

Provider Name: Shahida R. Munim MD
License: 38582
Medicare PIN:
SSN or EIN: 392011386

Total Charges:	$ 363.
Total Payments:	$ 0.
Total Adjustments:	$ 0.
Total Due This Visit:	**$ 363.**
Total Account Balance:	$ 413.

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: ____________________ Date: __________

INTERNAL MEDICINE ASSOCIATES
7200 W GREENFIELD AVENUE
WEST ALLIS, WI 53214
(414)543-1441

1/13/2011

Patient: Mary A. Brannon
2092 S 102nd Street
Milwaukee, WI 53227-1317

Chart #: BRAMA001
Case #: 17270

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
10/20/2010	Established Patient Level 4	99214		729.5	493.20	530.11	278.01	1	179.61
10/20/2010	All Rx Sent Electronically	G8443		729.5	493.20	530.11	278.01	1	0.0(
11/9/2010	Medicare Deductible	MEDDED						1	0.0(

Provider Information

Provider Name: Shahida R. Munim MD
License: 38582
Medicare PIN:
SSN or EIN: 392011386

Total Charges:	$ 179.
Total Payments:	$ 0.
Total Adjustments:	$ 0.
Total Due This Visit:	**$ 179.**
Total Account Balance:	$ 413

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: ______________________ Date: __________

AURORA VISITING NURSE ASN
DME VI 6.5.0
REVIEW BALANCE SHEET - ORDER
02/15/2011
09:23 AM

BRANNON, MARYANN
ACC#: 0000000A2TR6

DT SERVICE	PROC CODE	EXPLANATION	CHARGE	ALLOW	PAYMENT	PRIMARY	SECONDARY	TERTIARY	PATIENT	WA	BALANCE
						RUNNING BALANCE					
06/04/2010	E0163	COMMODE 3IN1 300LB	111.90	111.88		89.50	0.00	0.00	22.38	0.02	111.90
06/12/2010	WA	WRITE OFF ALLOWABLE			0.02	89.50	0.00	0.00	22.38	0.00	111.88
07/13/2010	PA	MX PMNT 07241292194			89.50	0.00	0.00	0.00	22.38	0.00	22.38
PG 001 BALANCE DUE ->			111.90	111.88	89.52	0.00	0.00	0.00	22.38	0.00	22.38
						AA:	0.00	DE:	0.00		
06/06/2010	E0143	WALKER ADULT & 5" W	132.51	108.81		87.05	0.00	0.00	21.76	23.70	132.51
06/06/2010	E0155	WALKER WHEEL 5IN 40	0.00	0.00		87.05	0.00	0.00	21.76	23.70	132.51
06/06/2010	A9281	REACHER 26IN	12.19	12.19		87.05	0.00	0.00	33.95	23.70	144.70
09/27/2010	WA	WRITE OFF ALLOWABLE			17.11	87.05	0.00	0.00	33.95	6.59	127.59
11/01/2010	WA	WRITE OFF ALLOWABLE			6.59	87.05	0.00	0.00	33.95	0.00	121.00
10/19/2010	PA	MX PMNT 08151769292			87.05	0.00	0.00	0.00	33.95	0.00	33.95
10/19/2010	PA	SERVICE NEVER COVER			0.00	0.00	0.00	0.00	33.95	0.00	33.95
		081517692921702			0.00	0.00	0.00	0.00	33.95	0.00	33.95
11/09/2010	PA	EDS PAYMENT 0126245			18.76	0.00	-18.76	0.00	33.95	0.00	15.19
11/09/2010	DE	T-19 CO-PAY 3.00			0.00	0.00	-18.76	0.00	33.95	0.00	15.19
11/09/2010	PA	RESUB MA COVER CHAR			0.00	0.00	-18.76	0.00	33.95	0.00	15.19
		012624527			0.00	0.00	-18.76	0.00	33.95	0.00	15.19
PG 002 BALANCE DUE ->			144.70	121.00	129.51	0.00	-18.76	0.00	33.95	0.00	15.19
						AA:	6.59	DE:	0.00		
TOTAL BALANCE DUE >>>			256.60	232.88	219.03	0.00	-18.76	0.00	56.33	0.00	37.57
						AA:	6.59	DE:	0.00		
UNAPPLIED DEPOSIT >>>						0.00	0.00	0.00	0.00		

March 31, 2011

Weigel, Carlson, Blau & Clemens, S.C.
Attn: Attorneys at Law
3732 W Wisconsin Avenue
Milwaukee, Wisconsin 53208

Regarding: Maryann Brannon
DOB: 09/29/1951
Our File # 18847

Enclosed you will find copies of our file on Maryann as you requested

Christine Smith
Records Coordinator

50 Pages @ .45 per record page = $22.50
211 Pages @ .25 per record page = $52.75

Invoice Total : $ 75.25

Please Remit To:
Gentiva Health Services
10400 W. Innovation Drive
Suite 320
Milwaukee, WI 53226

10400 west innovation drive • suite 320 • milwaukee, wi 53226 t 414.257.1156 • f 414.257.0696 www.gentiva.com

REISSUE/KMBRADFI MED 0000 03/24/11

Gentiva Health Services 10400 W INNOVATION DR WAUWATOSA WI53226 (800)285-7309	GENTIVA HEALTH SVC 10400 W INNOVATION WAUWATOSA WI53226 (800)285-7309	3a PAT. CNTL # 02471081901 b. MED. REC. # 024718847	4 TYPE OF BILL 0329
		5 FED. TAX NO. 11-2645333	6 STATEMENT COVERS PERIOD FROM 060510 THROUGH 080310

8 PATIENT NAME: b BRANNON MARYANN
9 PATIENT ADDRESS: a 2092 SOUTH 102ND STREET; b WEST ALLIS; c WI; d 53227

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
09291951	F	060510			5		01

39 VALUE CODES CODE	AMOUNT
a 61	33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0023	HHRG ORIGINAL E	2AHL1	060510			
0001	PAGE 1 OF 1	CREATION DATE	061710	TOTALS	.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MED-MEDICARE	527207	Y	Y	6924.46	.00	1225064926

57 OTHER PRV ID: 527207

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BRANNON M		394584069A		

63 TREATMENT AUTHORIZATION CODES: 10GA10GE11CJBPANAM
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: V5789 | V5416 | 84500 | 49390 | V5861

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1114917812 QUAL 1G U72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

REISSUE/KMBRADFI MED 0001 03/24/11

Gentiva Health Services
10400 W INNOVATION DR
WAUWATOSA WI53226
(800)285-7309

GENTIVA HEALTH SVC
10400 W INNOVATION
WAUWATOSA WI53226
(800)285-7309

3a PAT. CNTL # 02471081901
b. MED. REC. # 024718847
4 TYPE OF BILL 0329
5 FED. TAX NO. 11-2645333
6 STATEMENT COVERS PERIOD FROM 060510 THROUGH 080310

8 PATIENT NAME: BRANNON MARYANN
9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS WI 53227

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
09291951	F	060510			5		01

39 VALUE CODES: a 61 33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0421	PT VST/EVAL	G0151	060510	6	190.00	
0421	PT VST	G0151	060610	5	175.00	
0421	PT VST	G0151	060710	3	175.00	
0431	OT VST	G0152	060810	5	176.00	
0421	PT VST	G0151	060910	3	175.00	
0421	PT VST	G0151	061010	4	175.00	
0431	OT VST	G0152	061110	5	176.00	
0421	PT VST	G0151	061410	3	175.00	
0431	OT VST	G0152	061410	3	176.00	
0421	PT VST	G0151	061510	3	175.00	
0421	PT VST	G0151	061610	3	175.00	
0431	OT VST	G0152	061610	3	176.00	
0421	PT VST	G0151	061710	3	175.00	
0421	PT VST	G0151	061810	3	175.00	
0421	PT VST	G0151	062110	4	175.00	
0421	PT VST	G0151	062310	3	175.00	
0431	OT VST	G0152	062310	3	176.00	
0421	PT VST	G0151	062410	3	175.00	
0421	PT VST	G0151	062810	3	175.00	
0421	PT VST	G0151	063010	3	175.00	
0421	PT VST	G0151	070110	3	175.00	
0561	MSS VST	G0155	070210	5	257.00	
0001	PAGE 1 OF 3	CREATION DATE	061710	TOTALS	3952.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MED-MEDICARE	527207	Y	Y	6924.46	.00	1225064926

57 OTHER PRV ID: 527207

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BRANNON M		394584069A		

63 TREATMENT AUTHORIZATION CODES: 10GA10GE11CJBPANAM
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: V5789 V5416 84500 49390 V5861

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1114917812 QUAL 1G U72035
LAST WILSON FIRST SEAN
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 124394536 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

REISSUE/KMBRADFI MED 0001 03/24/11

Gentiva Health Services
10400 W INNOVATION DR
WAUWATOSA WI53226
(800)285-7309

GENTIVA HEALTH SVC
10400 W INNOVATION
WAUWATOSA WI53226
(800)285-7309

3a PAT. CNTL # 02471081901
b. MED. REC. # 024718847
4 TYPE OF BILL 0329
5 FED. TAX NO. 11-2645333
6 STATEMENT COVERS PERIOD FROM 060510 THROUGH 080310

8 PATIENT NAME: BRANNON MARYANN
9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS WI 53227

10 BIRTHDATE 09291951 | 11 SEX F | 12 ADMISSION DATE 060510 | 15 SRC 5 | 17 STAT 01

39 VALUE CODES: a 61 33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0421	PT VST	G0151	070610	3	175.00	
0561	MSS VST	G0155	070810	5	257.00	
0421	PT VST	G0151	070810	3	175.00	
0421	PT VST	G0151	071210	4	175.00	
0551	RN VST	G0154	071510	4	160.00	
0421	PT VST	G0151	071510	4	175.00	
0421	PT VST	G0151	071610	3	175.00	
0551	RN VST	G0154	071610	5	160.00	
0551	RN VST	G0154	071710	3	160.00	
0551	RN VST	G0154	071810	3	160.00	
0551	RN VST	G0154	071910	3	160.00	
0421	PT VST	G0151	071910	4	175.00	
0551	RN VST	G0154	072010	2	160.00	
0421	PT VST	G0151	072010	3	175.00	
0421	PT VST	G0151	072110	2	175.00	
0421	PT VST	G0151	072210	3	175.00	
0551	RN VST	G0154	072310	3	160.00	
0421	PT VST	G0151	072310	3	175.00	
0551	RN VST	G0154	072410	2	160.00	
0421	PT VST	G0151	072610	3	175.00	
0551	RN VST	G0154	072610	3	160.00	
0561	MSS VST	G0155	072710	3	257.00	
0001	PAGE 2 OF 3	CREATION DATE	061710	TOTALS	3879.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MED-MEDICARE	527207	Y	Y	2972.46	906.54	1225064926

57 OTHER PRV ID: 527207

58 INSURED'S NAME: BRANNON M
60 INSURED'S UNIQUE ID: 394584069A

63 TREATMENT AUTHORIZATION CODES: 10GA10GE11CJBPANAM

67 DX: V5789 | V5416 | 84500 | 49390 | V5861

76 ATTENDING NPI 1114917812 QUAL 1GU72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL
78 OTHER NPI QUAL
79 OTHER NPI QUAL

80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HE[REOF]

REISSUE/KMBRADFI MED 0001 03/24/11

Gentiva Health Services	GENTIVA HEALTH SVC	3a PAT. CNTL # 02471081901	4 TYPE OF BILL 0329
10400 W INNOVATION DR	10400 W INNOVATION	b. MED. REC. # 024718847	
WAUWATOSA WI53226	WAUWATOSA WI53226	5 FED. TAX NO. 11-2645333	6 STATEMENT COVERS PERIOD FROM 060510 THROUGH 080310
(800)285-7309	(800)285-7309		

8 PATIENT NAME: BRANNON MARYANN

9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS WI 53227

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
09291951	F	060510			5		01

39 VALUE CODES CODE	AMOUNT
61	33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0421	PT VST	G0151	072710	3	175.00	
0421	PT VST	G0151	072810	3	175.00	
0551	RN VST	G0154	072810	4	160.00	
0421	PT VST	G0151	072910	3	175.00	
0551	RN VST	G0154	073010	2	160.00	
0421	PTA VST	G0151	073010	4	175.00	
0551	RN VST	G0154	080110	4	160.00	
0421	PT VST	G0151	080210	4	175.00	
0551	RN VST	G0154	080310	6	160.00	
0001	PAGE 3 OF 3	CREATION DATE	061710	TOTALS	1515.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MED-MEDICARE	527207	Y	Y		1515.00	1225064926

57 OTHER PRV ID: 527207

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BRANNON M		394584069A		

63 TREATMENT AUTHORIZATION CODES: 10GA10GE11CJBPANAM

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX: V5789 V5416 84500 49390 V5861

67 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI

74 PRINCIPAL PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1114917812 QUAL 1G U72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

81 CC

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HER

REISSUE/KMBRADFI MED 0000 03/24/11

Gentiva Health Services	GENTIVA HEALTH SVC	3a PAT. CNTL #	02471082165
10400 W INNOVATION DR	10400 W INNOVATION	b. MED. REC. #	024718847
WAUWATOSA WI53226	WAUWATOSA WI53226	4 TYPE OF BILL	0329
(800)285-7309	(800)285-7309		

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH
11-2645333	080410	091610

8 PATIENT NAME: BRANNON MARYANN

9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS, WI 53227

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
09291951	F	060510		1			01

39 VALUE CODES CODE	AMOUNT
61	33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0023	HHRG CONTINUING	2AFK2	080410			
0001	PAGE 1 OF 1	CREATION DATE	081310	TOTALS	.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MED-MEDICARE	527207	Y	Y	4187.67	.00	1225064926

57 OTHER PRV ID: 527207

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
BRANNON M		394584069A		

63 TREATMENT AUTHORIZATION CODES: 10GA10IF41BCDDCCAB

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX: V5789 V5416 84500 49390

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1114917812 QUAL 1GU72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

REISSUE/KMBRADFI MED 0001 03/24/11

Gentiva Health Services
10400 W INNOVATION DR
WAUWATOSA WI53226
(800)285-7309

GENTIVA HEALTH SVC
10400 W INNOVATION
WAUWATOSA WI53226
(800)285-7309

3a PAT. CNTL # 02471082165
b. MED. REC. # 024718847
4 TYPE OF BILL 0329
5 FED. TAX NO. 11-2645333
6 STATEMENT COVERS PERIOD FROM 080410 THROUGH 091610

8 PATIENT NAME: BRANNON MARYANN
9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS WI 53227

10 BIRTHDATE 09291951 | 11 SEX F | 12 ADMISSION DATE 060510 | 14 TYPE 1 | 17 STAT 01

39 VALUE CODES: a 61 33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0421	PT VST	G0151	080410	3	175.00	
0551	RN VST	G0154	080510	3	160.00	
0421	PT VST	G0151	080610	3	175.00	
0551	RN VST	G0154	080710	2	160.00	
0551	RN VST	G0154	080910	3	160.00	
0421	PT VST	G0151	081010	3	175.00	
0421	PT VST	G0151	081110	3	175.00	
0551	RN VST	G0154	081210	3	160.00	
0421	PT VST	G0151	081310	3	175.00	
0551	RN VST	G0154	081410	4	160.00	
0421	PTA VST	G0151	081610	4	175.00	
0551	RN VST	G0154	081610	2	160.00	
0421	PTA VST	G0151	081810	4	175.00	
0551	RN VST	G0154	081810	3	160.00	
0421	PTA VST	G0151	081910	4	175.00	
0551	RN VST	G0154	081910	2	160.00	
0551	RN VST	G0154	082010	3	160.00	
0551	RN VST	G0154	082110	2	160.00	
0551	RN VST	G0154	082210	2	160.00	
0551	RN VST	G0154	082310	3	160.00	
0421	PT VST	G0151	082310	3	175.00	
0551	RN VST	G0154	082410	3	160.00	
0001	PAGE 1 OF 2	CREATION DATE	081310	TOTALS	3655.00	

50 PAYER NAME: MED-MEDICARE | 51 HEALTH PLAN ID: 527207 | 52 REL INFO: Y | 53 ASG BEN: Y | 54 PRIOR PAYMENTS: 4187.67 | 55 EST. AMOUNT DUE: .00 | 56 NPI: 1225064926 | 57 OTHER PRV ID: 527207

58 INSURED'S NAME: BRANNON M | 60 INSURED'S UNIQUE ID: 394584069A

63 TREATMENT AUTHORIZATION CODES: 10GA10IF41BCDDCCAB

66 DX: V5789 V5416 84500 49390

76 ATTENDING NPI 1114917812 QUAL 1GU72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

REISSUE/KMBRADFI MED 0001 03/24/11

Gentiva Health Services
10400 W INNOVATION DR
WAUWATOSA WI53226
(800)285-7309

GENTIVA HEALTH SVC
10400 W INNOVATION
WAUWATOSA WI53226
(800)285-7309

3a PAT. CNTL # 02471082165
b. MED. REC. # 024718847
4 TYPE OF BILL 0329
5 FED. TAX NO. 11-2645333
6 STATEMENT COVERS PERIOD FROM 080410 THROUGH 091610

8 PATIENT NAME: BRANNON MARYANN
9 PATIENT ADDRESS: 2092 SOUTH 102ND STREET, WEST ALLIS WI 53227

10 BIRTHDATE 09291951 | 11 SEX F | 12 ADMISSION DATE 060510 | 14 TYPE 1 | 17 STAT 01

39 VALUE CODES: a 61 33340.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0551	RN VST	G0154	082510	2	160.00	
0551	RN VST	G0154	082610	2	160.00	
0421	PT VST	G0151	082710	3	175.00	
0551	RN VST	G0154	082710	2	160.00	
0551	RN VST	G0154	082810	2	160.00	
0551	RN VST	G0154	082910	3	160.00	
0551	RN VST	G0154	083010	3	160.00	
0421	PT VST	G0151	083110	3	175.00	
0551	RN VST	G0154	083110	2	160.00	
0551	RN VST	G0154	090110	2	160.00	
0421	PT VST	G0151	090210	3	175.00	
0551	RN VST	G0154	090210	3	160.00	
0421	PT VST	G0151	090310	3	175.00	
0551	RN VST	G0154	090310	2	160.00	
0551	RN VST	G0154	090610	2	160.00	
0551	RN VST	G0154	090810	2	160.00	
0421	PT VST	G0151	090810	3	175.00	
0421	PT VST	G0151	091010	3	175.00	
0551	RN VST	G0154	091010	2	160.00	
0421	PT VST	G0151	091310	3	175.00	
0551	RN VST	G0154	091310	2	160.00	
0421	PT VST	G0151	091610	3	175.00	
0001	PAGE 2 OF 2	CREATION DATE	081310	TOTALS	3640.00	

50 PAYER NAME: MED-MEDICARE | 51 HEALTH PLAN ID: 527207 | 52 REL. INFO: Y | 53 ASG. BEN.: Y | 55 EST. AMOUNT DUE: 3107.30 | 56 NPI: 1225064926 | 57 OTHER PRV ID: 527207

58 INSURED'S NAME: BRANNON M | 60 INSURED'S UNIQUE ID: 394584069A

63 TREATMENT AUTHORIZATION CODES: 1OGA1OIF41BCDDGCAB

67 DX: V5789 | V5416 | 84500 | 49390

76 ATTENDING NPI 1114917812 QUAL 1G U72035
LAST WILSON FIRST SEAN

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 24394536 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

HAOP0011-01
DATE: 6/14/10
TIME: 7:50:37

GENTIVA HEALTH SERVICES
PATIENT INTAKE REPORT
OFFICE: 0247 PATIENT: 18847 DATE ENTERED: 06/03/2010

```
*** Patient Information ***
First Name........ MARYANN      MI:
Last Name......... BRANNON
Attention.........
Address Line 1.... 2092 SOUTH 102ND STREET
Address Line 2.... APT 109
City.............. WEST ALLIS          State: WI  Zip: 53227 0000
Phone #1.......... 414-731-1563        Phone #2.......
Unique ID Nbr..... 394584069A          Residence...... HOME
Sex: F   Race: 1   Marital Sts: M      Birth Date..... 09/29/1951     Age: 58

*** Referral Information ***
Patient Status.......... 30             Anticipated SOC: 6/05/10    Source: 46
Primary Referral #1..... 0000004747        ASPEN ORTHOPAEDIC & REHAB
Referral Source #2...... 0000000000
Referral Source #3...... 0000000000

 emos:

*** Admission Information ***
Patient Status.......... 30            Medicare Statue Code.... 30
Verbal Start of Care.... 6/04/10       Start of Care........... 6/05/10
Cert/Recert From........ 6/05/10       Cert/Recert To.......... 8/03/10  Cert/Non Cert: C
Discharge Date.......... 0/00/00       Medicare Discharge Data. 0/00/00
Municipality Code....... 79            Product Line Codes...... JRP
Disaster Code........... 3             Aud:   Visual:   Speech:   Tot:   Pty:
                                       Adm Source: 5   Variance Code: 000

*** Physician/Hospital Information ***
Physician #1.....0000005096 WILSON SEAN          NPI#:1114917812 262-780-4400  19474 WEST NORTH AVE BROOKFIELD   WI 53040
                                                                              SUITE 201
Physician #2.....0000000000                      NPI#:

Last Inpatient Location. 0000000000
Hospital Admit Date..... 0/00/00       Hospital Discharge Date. 0/00/00

*** Team Information ***
CSS: 02  SUP: 02   CASE MGR: 00753    COFFMAN, ANNE
RN: N 00000  LPN: N 00000  HHA: N 00000  PCA: N 00000  PT: N 00000  OT: N 00000  OH: N 00000  ST: N 00000  MSW: N 00000

*** Diagnosis Information ***
Admitting ICD9.... V5789  6/05/10 00  REHABILITATION PROC NEC
Principal ICD9.... V5789  6/05/10 00  REHABILITATION PROC NEC
Acuity............

*** Payor Information ***
Payors: Primary... 10 00 00 00 00
HIC#.............. 394584069A          Medicaid#.........
Insurance ID#.....                     Social Security#.. 394584069
Primary Acct ID... 0000                Account Name......
Credit Limit...... 0000000             Tax Code.......... 0

*** Medicare Information ***          Entitlement   Expiration              Entitlement   Expiration
Intermediary Code: 046     Part A: Y   11/01/2009    0/00/0000    Part B: Y  11/01/2009    0/00/0000
------------------------------------------------------------------------------------------------------
 Tickler Date   Code   Comment                                                           Date Entered
   6/04/10 1           Per Donna C @ WAMH Patient to be D/C Fri the 4th; SOC Sat;           6/04/10
   6/03/10 1           PT/OT eval and treat : transfers tech ; gait training hm safety      6/03/10
   6/03/10 1           INR per protocol;  DX: S/P orif R ankle;                             6/03/10
   6/03/10 C           MEV  Complete            GREAT LAKES       06/03/2010    15:46:11    6/03/10
RN Signature: ______________________________
```

*** POT Orders ***

Eff Dt	Disc	Frequency and Duration			End Dt	Units
060510	OT	02	002	01W001	000000	005
060510	PT	05	002	02W001	000000	012

RN Signature: ______________________________

06-03-'10 15:31 FROM-Aspen Orthopaedics 414-328-8686 T-172 P001/002 F-992

18847

Aspen Orthopaedic & Rehabilitation Specialists, S.C.

- ☐ LEE M. TYNE, M.D.
- ☐ PATRICK W. CUMMINGS, M.D.
- ☐ JAMES P. WOOD, M.D.
- ☐ JEFFREY E. LARSON, M.D.
- ☐ AMY K. FRANTA, M.D.
- ☐ RYAN J. KEHOE, M.D.
- ☑ SEAN E. WILSON, D.P.M.
- ☐ ROBBY A. AMIOT, D.P.M.
- ☐ JOEL DRIER, PA-C

19475 W. NORTH AVENUE, SUITE 201
BROOKFIELD, WISCONSIN 53045
(262) 780-4400 FAX: (262) 780-4425

2424 S. 90TH STREET, SUITE 500
WEST ALLIS, WISCONSIN 53227
(414) 328-8600 FAX: (414) 328-8686

721 AMERICAN AVENUE, SUITE 205
WAUKESHA, WISCONSIN 53188
(262) 928-8600 FAX: (262) 928-8606

NAME Mary Ann Brannon DOB 9/29/51

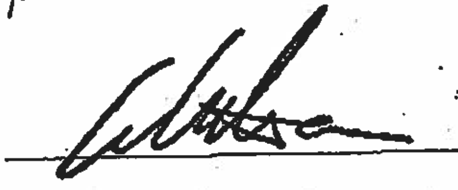
ADDRESS ______ DATE 6/3/10

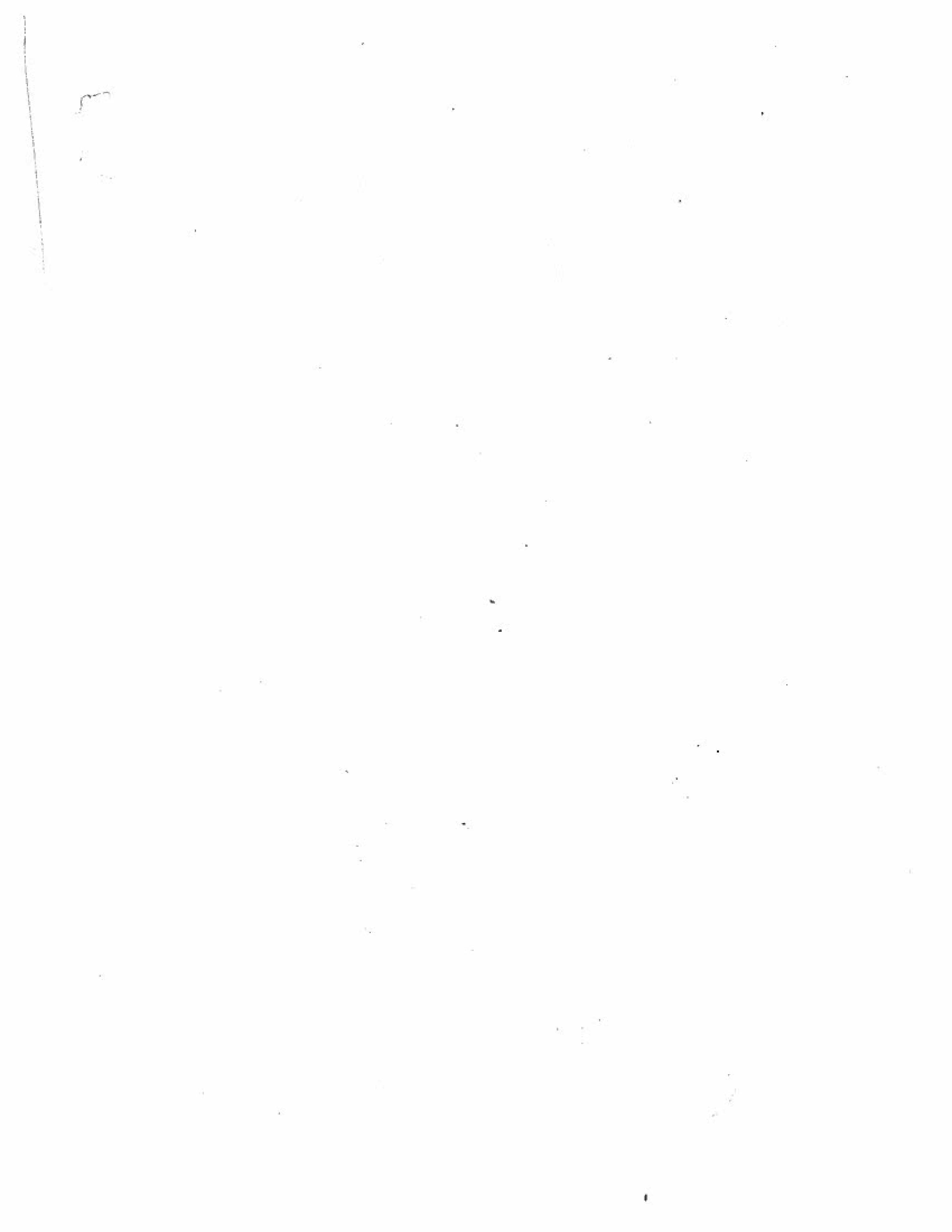
℞ PT/OT: Eval + Treat
Transfer techniques
Gait training
Home safety
INR's per protocol

DX: S/P ORIF
Ⓡ ankle

Label
Refills: 0 1 2 3

Pt. at West Allis
Call Donna -





Statement

Diagnostic Mobile Imaging LLC
N4 W22540 Bluemound Road
Waukesha, WI 53186
262-544-9825

Date
1/12/2011

To:
Maryann Brannon 2092 S. 102nd Milwaukee, WI PATIENT: MARYANN BRANNON

Amount Due	Amount Enc.
$9.00	

Date	Transaction	Amount	Balance
07/31/2010	Balance forward		0.00
08/03/2010	AP & Lateral Chest Xray	258.00	258.00
09/27/2010	PMT Medicare	-142.37	115.63
09/27/2010	Discount Medicare	-80.04	35.59
10/01/2010	PMT	-2.93	32.66
10/01/2010	Discount	-23.66	9.00

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
9.00	0.00	0.00	0.00	0.00	$9.00

Comprehensive Adult Assessment, 485 P.O.C. Worksheet and Outcome and Assessment Information Set (OASIS-C, 1/2010)

COLOR KEY: GREEN Ink = OASIS Items; = PPS Indicators; [1] RED Ink = Specific 485 Items (completed per agency policy) at SOC; BLACK Ink = Additional Comprehensive Assessment Items

START OF CARE/RESUMPTION OF CARE - PHYSICAL THERAPY

Items to be used at this Time Point: M0032, M0080-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250

EMPLOYEE TIME SLIP

[X] Cert. [ ] Non-Cert. | Location Name: Milwaukee | Location No.: 0247 | Client No.: 18847

Employee No.: 0783 | Employee Name (Last, First): Offman Anne | [6] Patient Name (Last, First): Brannon, Mary Ann

Pay/Bill Code	Shift	Date of Service (Month / Day / Year)	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
21		6 / 5 / 10	1145 am	12:15 pm	1140 am	1144 am	4	Mileage ___ Bill Mileage [ ] Yes [ ] No

Patient Time	Non-Billable Visit Duration (NBD)	Chart Time	Total Time
Hrs 45 Min	Hrs Min	Hrs 30 Min	1 Hrs 15 Min

[ ] Bill/Pay [ ] Bill [ ] Pay [ ] No Pay/No Bill [ ] Overtime

Override Bill Rates [ ] Yes [ ] No
Override Pay Rates [ ] Yes [ ] No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Supplies: Code / Quantity

Patient Signature: X Mary A Brannon
Employee Signature: AOffman AMS GCS
Approved by Initials/Date: 6-14-10

CLINICAL RECORD ITEMS

[2] Start of Care Date: 06 / 05 / 2010

[3] Certification Period From: 6/5/10 To: 8/3/10

[24] Primary Ordering Physician/Phone No.: Dr Wilson 262-780-4400

(M0032) Resumption of Care Date: month __ / day __ / year ____ [X] NA - Not Applicable

Secondary Physician's Name/Phone No.:
Emergency Contact Name/Phone No.:
Other Phone No.:

(M0080) Discipline of Person Completing Assessment:
[ ] 1 - RN [X] 2 - PT [ ] 3 - SLP/ST [ ] 4 - OT

(OM) (M0090) Date Assessment Completed: 06 / 09 / 2010

(OM) (M0100) This Assessment is Currently Being Completed for the Following Reason:
Start/Resumption of Care [X] 1 - Start of care – further visits planned [ ] 3 - Resumption of care (after inpatient stay)

P (OM) (M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
06 / 05 / 2010 [Go to *M0110*, if date entered]
[ ] NA - No specific SOC date ordered by physician

P (OM) (M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
month __ / day __ / year ____

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
[X] 1 - Early [ ] 2 - Later [ ] UK - Unknown [ ] NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

(M0150) Current Payment Sources for Home Care: *(Mark all that apply.)*
- [ ] 0 - None; no charge for current services
- [X] 1 - Medicare (traditional fee-for-service)
- [ ] 2 - Medicare (HMO/managed care/Advantage plan)
- [ ] 3 - Medicaid (traditional fee-for-service)
- [ ] 4 - Medicaid (HMO/managed care)
- [ ] 5 - Workers' compensation
- [ ] 6 - Title programs (e.g., Title III, V, or XX)
- [ ] 7 - Other government (e.g., TriCare, VA, etc.)
- [ ] 8 - Private insurance
- [ ] 9 - Private HMO/managed care
- [ ] 10 - Self-pay
- [ ] 11 - Other (specify): ____
- [ ] UK - Unknown

DEMOGRAPHICS AND PATIENT HISTORY

Ability of Patient to handle personal finances
[ ] Independent [X] Needs Assistance [ ] Totally Dependent
Comments: husband @ finances

(M1000) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? *(Mark all that apply.)*
- [ ] 1 - Long-term nursing facility (NF)
- [ ] 2 - Skilled nursing facility (SNF/TCU)
- [X] 3 - Short-stay acute hospital (IPP S)
- [ ] 4 - Long-term care hospital (LTCH)
- [ ] 5 - Inpatient rehabilitation hospital or unit (IRF)
- [ ] 6 - Psychiatric hospital or unit
- [ ] 7 - Other (specify): ____
- [ ] NA - Patient was not discharged from an inpatient facility [Go to *M1016*]

Name of Hospital/Facility:

Comments:

(M1005) Inpatient Discharge Date: (most recent):
06 / 04 / 2010 [ ] UK - Unknown

Comments

Patient Name (last, first): Mary Ann Brannon Patient Number: 18847

Communication with: Anne Coffman (Name) PT (Title)

Upon review of OASIS documentation and communication with the assessing professional, the following changes will be made to the assessment completed on 6-5-10

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Case Mix Diagnoses	
Column 1	Column 2	Column 3	Column 4
Description	ICD-9-CM/Symptom Control Rating	Description/ICD-9-CM	Description/ICD-9-CM
(M1020) Primary Diagnosis a. V5789	a. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4	a. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4	a. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4
(M1022) Other Diagnoses b. V5416 aftercare Fx ankle	b. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4	b. ___ (___ . ___)	b. ___ (___ . ___)
c. 84500	c. (___ . ___) ☐0 ☒1 ☐2 ☐3 ☐4	c. ___ (___ . ___)	c. ___ (___ . ___)
d. 49390	d. (___ . ___) ☐0 ☒1 ☐2 ☐3 ☐4	d. ___ (___ . ___)	d. ___ (___ . ___)
e. V5861	e. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4	e. ___ (___ . ___)	e. ___ (___ . ___)
f. V5883	f. (___ . ___) ☐0 ☐1 ☐2 ☐3 ☐4	f. ___ (___ . ___)	f. ___ (___ . ___)

M1012:

a. ___ Date: ___ ICD-9: 8248, 84500

b. ORIF Ankle Date: ___ ICD-9: 7936

c. ___ Date: ___ ICD-9: 84500

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

M ___ should be ___ explanation of changes: ___

Other: ___

Name/Title: Rosalinda M Tavela RN Date: 6-16-10

Signature: ___ Time: ___ a.m. ___ p.m.

©Gentiva Health Services

Patient Name (Last, First) Brannon Mary Ann

Client No. 18847

DEMOGRAPHICS AND PATIENT HISTORY (continued)

(M1010) List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-CM Code		Inpatient Facility Diagnosis	ICD-9-CM Code
a.	(R) ankle fx	___ . __	d.		___ . __
b.	(R) ankle sprain	___ . __	e.		___ . __
c.		___ . __	f.		___ . __

Comments

(M1012) List each Inpatient Procedure and the associated ICD-9-CM procedure code relevant to the plan of care.

	Inpatient Procedure	Procedure Code	Date
a.	(R) ankle ORIF	___ . __	06/03/2010
b.		___ . __	__/__/____
c.		___ . __	__/__/____
d.		___ . __	__/__/____

☐ NA - Not applicable ☐ UK - Unknown

Comments

(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-CM Code		Changed Medical Regimen Diagnosis	ICD-9-CM Code
a.	~~(R) ankle fx~~	___ . __	e.		___ . __
b.	~~(R) ankle sprain~~	___ . __	f.		___ . __
c.		___ . __			
d.		___ . __			

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

Comments

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. ***(Mark all that apply.)***

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☒ 7 - None of the above
- ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ☐ UK - Unknown

Significant Past Health History/Surgical Procedures/Labs

Asthma x many yrs, reflux

Immunization:

Flu ☐ No ☐ Unknown ☐ Yes, Date: ______

Pneumonia ☐ No ☐ Unknown ☐ Yes, Date: ______

Comments

HHRG (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;
Rate the degree of symptom control for the condition listed in Column 1 using the following scale:
- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM/Symptom Control Rating	Description/ICD-9-CM	Description/ICD-9-CM
(M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
a. [illegible] Date: 6/3/10 O/E	a. [illegible] ☐0 ☐1 ☐2 ☒3 ☐4	a. [illegible]	a. [illegible]
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. aftercare [illegible] Date: 6/5/10 O/E	b. [illegible] ☐0 ☐1 ☐2 ☒3 ☐4	b. [illegible]	b. [illegible]
c. anticoagulant monitoring Date: 6/5/10 O/E	c. [illegible] ☐0 ☐1 ☒2 ☐3 ☐4	c. [illegible]	c. [illegible]
d. muscle weakness Date: 6/5/10 O/E	d. [illegible] ☐0 ☐1 ☒2 ☐3 ☐4	d. [illegible]	d. [illegible]
e. asthma Date: 6/08 O/E	e. [illegible] ☐0 ☐1 ☐2 ☒3 ☐4	e. [illegible]	e. [illegible]
f. Date: O/E	f. (___ . __) ☐0 ☐1 ☐2 ☐3 ☐4	f. (___ . __)	f. (___ . __)

DEMOGRAPHICS AND PATIENT HISTORY (continued)

(M1030) Therapies the patient receives at home: *(Mark all that apply.)*

- [ ] 1 - Intravenous or infusion therapy (excludes TPN)
- [ ] 2 - Parenteral nutrition (TPN or lipids)
- [ ] 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- [x] 4 - None of the above

Comments / Interventions

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? *(Mark all that apply.)*

- [ ] 1 - Recent decline in mental, emotional, or behavioral status
- [ ] 2 - Multiple hospitalizations (2 or more) in the past 12 months
- [x] 3 - History of falls (2 or more falls-or any fall with an injury-in the past year)
- [x] 4 - Taking five or more medications
- [ ] 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion
- [ ] 6 - Other
- [ ] 7 - None of the above

(M1034) Overall Status: Which description best fits the patient's overall status? *(Check ONE)*

- [ ] 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- [x] 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- [ ] 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- [ ] 3 - The patient has serious progressive conditions that could lead to death within a year.
- [ ] UK - The patient's situation is unknown or unclear.

Comments

20 PROGNOSIS: [ ] Poor [ ] Guarded [ ] Fair [ ] Good [x] Excellent

22 Terminal Care Interventions: [ ] DNR

(M1036) Risk Factors either present or past, likely to affect current health status and/or outcome: *(Mark all that apply.)*

- [x] 1 - Smoking
- [ ] 2 - Obesity
- [ ] 3 - Alcohol dependency
- [ ] 4 - Drug dependency
- [x] 5 - None of the above (error)
- [ ] UK - Unknown

Comments: just quitting smoking now

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? *(Check ONE box only.)*

Living Arrangement	Availability of Assistance: Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	[ ] 01	[ ] 02	[ ] 03	[ ] 04	[ ] 05
b. Patient lives with other person(s) in the home	[ ] 06	[ ] 07	[x] 08	[ ] 09	[ ] 10
c. Patient lives in congregate situation (e.g., assisted living)	[ ] 11	[ ] 12	[ ] 13	[ ] 14	[ ] 15

Comments: Spouse works part time – Ø home days consistently

Marital Status [ ] Single [x] Married [ ] Divorced [ ] Widowed

Religious/Cultural Issues and Significance Ø

Suspected Abuse/Neglect, i.e.: *(Please circle)* unexplained bruises, inadequate food, fearful of family member, c/g exploitation of funds, sexual abuse, neglect, left unattended if needs constant supervision. Other: Ø

21 HOME ENVIRONMENT/ SAFETY INTERVENTIONS:
Assess: [x] Architectural Barriers [x] Patient Safety Awareness
Instruct: [x] Home Safety Measures [ ] Other:
Additional Orders (specify):

15 SAFETY MEASURES: [x] Anticoagulant Precautions [x] Environmental [x] Bathroom [ ] HME [ ] Electrical [ ] Other (specify): [ ] Medication [ ] Fire

Is patient currently taking a prescribed anticoagulant? [x] Yes [ ] No
Will patient receive PT/INR monitoring as part of plan? [x] Yes [ ] No

HOME ENVIRONMENT: / **SAFETY AWARENESS:**

Item	N/A	Inside / Yes	Outside / No	Safety Awareness Yes	Safety Awareness No
Steps/Stairs	[x] N/A	[ ] Inside	[ ] Outside	[ ] Yes	[ ] No
Railing	[x] N/A	[ ] Inside	[ ] Outside	[ ] Yes	[ ] No
Chair Lift	[x] N/A	[ ] Inside	[ ] Outside	[ ] Yes	[ ] No
Elevator	[x] N/A	[ ] Inside	[ ] Outside	[ ] Yes	[ ] No
Scatter Rugs	[ ] N/A	[x] Yes	[ ] No	[ ] Yes	[x] No
Cords	[ ] N/A	[x] Yes	[ ] No	[ ] Yes	[x] No
Doorways	[ ] N/A	[x] Yes	[ ] No	[ ] Yes	[x] No
Furniture	[ ] N/A	[x] Yes	[ ] No	[ ] Yes	[x] No

EMERGENCY / DISASTER PLAN: Disaster Priority Code III

I. Patients who require skilled interventions that must be provided as scheduled.
II. Patients requiring a moderate level of skilled care that should be provided the day scheduled, if possible, but the patient would not be at risk or in discomfort.
III. Patients who can safely miss scheduled visits

Has an effective Home Escape Route been established? [x] Yes [ ] No Explain: pt/spouse aware of how to exit

Does the Pt/Cg have an Evacuation Plan? [x] Yes [ ] No Explain:

Does home environment impact patient's ability to meet goals? [ ] Yes [x] No
If yes, explain and notify Clinical Manager (including follow-up)

Comments

Oxygen Fire High-Risk Assessment [x] No oxygen in the home; therefore, risk assessment not completed

Circle the score of each item that is true and total circled scores at bottom	Score
Patient is 65 years or older	1
Patient lives alone	1
Patient's home lacks smoke detectors or has non-functional smoke detectors	1
Patient's home lacks fire extinguisher or patient/family do not know how to use it	1
Patient has cognitive impairment	1
Patient has a history of smoking while oxygen in use	1
A total score of 3 or higher indicates the patient is at high-risk for oxygen fires and should have Oxygen Fire Prevention Protocol implemented. Total Score	

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Patient Name (Last, First) Brennan Mary Ann

Client No. 17847

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

- [x] 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- [ ] 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- [ ] 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

- [ ] Glasses
- [ ] Glaucoma: [ ] R [ ] L
- [ ] Blurred Vision: [ ] R [ ] L
- [ ] Nystagmus
- [ ] Saccades
- [ ] Cataracts: [ ] R [ ] L
- [ ] Contacts: [ ] R [ ] L
- [ ] Macular Degeneration: [ ] R [ ] L
- [ ] Convergence: [ ] WNL [ ] ______
- [ ] Pupillary Reflex: [ ] WNL [ ] ______
- [ ] Other: ______

Comments

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- [x] 0 - Adequate: hears normal conversation without difficulty.
- [ ] 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- [ ] 2 - Severely Impaired: absence of useful hearing.
- [ ] UK - Unable to assess hearing.

EARS
Ear Pain? [ ] L [ ] R Tinnitus? [ ] L [ ] R
Hearing Loss? [ ] L [ ] R Aid Used? [ ] L [ ] R

Comments

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

- [x] 0 - Understands: clear comprehension without cues or repetitions.
- [ ] 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- [ ] 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- [ ] 3 - Rarely/Never Understands.
- [ ] UK - Unable to assess understanding.

Comments

OM **(M1230) Speech and Oral (Verbal) Expression of Language** (in patient's own language):

- [x] 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- [ ] 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- [ ] 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- [ ] 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- [ ] 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- [ ] 5 - Patient nonresponsive or unable to speak.

Comments

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT

18B ACTIVITIES PERMITTED: [ ] No Restrictions

- [x] Precautions (specify): NWB (R) LE
- [ ] Complete Bed Rest
- [ ] Partial Weight Bearing (specify): ______
- [ ] Independent at Home
- [ ] Bed Rest with BRP
- [x] Wheelchair
- [ ] Transfer Bed/Chair
- [x] Walker
- [ ] Up as Tolerated
- [ ] Cane
- [x] Exercises Prescribed
- [ ] Crutches
- [ ] Other: ______

- [x] Upper/Lower Quarter Screen Completed *(functional deficits documented below)*

STRENGTH GRADES: N (5) = NORMAL G (4) = GOOD F (3) = FAIR P (2) = POOR T (1) = TRACE 0 = ZERO **ROM MEASUREMENTS**

MUSCLE STRENGTH & ROM			PROM Right	PROM Left	AROM Right	AROM Left	STRENGTH Right	STRENGTH Left
SHOULDER:	Flexion	0-180					4/5	4/5
	Abduction	0-180						
	Int. Rot.	0-70						
	Ext. Rot.	0-90						
ELBOW:	Flexion	0-145						
	Extension	0-0						
FOREARM:	Supination	0-85						
	Pronation	0-85						
WRIST:	Flexion	0-70						
	Extension	0-70						
HIP:	Flexion	0-120						
	Extension	0-25						
	Abduction	0-45						
	Int. Rot.	0-45						
	Ext. Rot.	0-45						
KNEE:	Flexion	0-135						
	Extension (-)	0						
	Hyperextension (+)	0-15						
ANKLE:	Dorsiflex	0-20						
	Plantarflex	0-50						

Hand Dominance: [ ] R [ ] L

Comments
(L) ankle NT → sprain/fx
unable to MMT (R) LE 2° fx/surgery — estimate 4-/5 based on mmt
did not test (L) LE 2° extreme/severe pain — estimate 4-/5

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MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT (continued)

FUNCTIONAL BALANCE

Describe: (Static, Dynamic-Sitting, Standing)

neg max @ + UE support 2° NWB (R)

Testing Performed: ***(required by Gentiva Safe Strides® Program)***

☐ Tinetti ___/28 ☐ NT | ☐ DVA ☐ + ☐ - ☐ NT | Semmes-Weinstein score 5.07 monofilament: R ___/5 ☐ NT L ___/5 ☐ NT | Modified CTSIB: Position 1 ___/30 ☐ NT Position 2 ___/30 ☐ NT Position 3 ___/30 ☐ NT Position 4 ___/30 ☐ NT

☐ BERG ___/56 ☐ NT | ☐ BPPV ☐ + ☐ - ☐ NT | Gait speed: ___ feet ___ min ___ sec

☐ DGI ___/24 ☐ NT | ☐ ABC ___% ☐ NT

Comments

POSTURE/COORDINATION/SYMMETRY

Describe:

Reflexes:

TONE/MOVEMENT

☒ WNL
☐ Fasciculations
☐ Atrophy

Describe:

ENDURANCE/FUNCTIONAL ACTIVITIES TOLERANCE

☐ Good
☐ Fair
☒ Poor

Describe: 2° pain

JOINTS

☐ No Deficit
☐ Enlarged
☐ Warm/Red
☒ Painful
☐ Stiff

Describe: (B) ankle severe pain see below

SENSATION/PROPRIOCEPTION

☐ WNL
☐ Light Touch
☐ Vibration
☐ Joint Position Sense

Describe: NT

21 MUSCULOSKELETAL INTERVENTIONS:

Assess:
☒ Balance/Posture/Coordination
☐ Tone/Spasticity of ___
☒ Functional Activity Tolerance

Perform:
☐ Body Mechanics
☐ Balance and Coordination Training/Retraining
☒ Therapeutic Exercise
☐ E-Stim to ___ area for ___ minutes for ___ visits, effective ___
☒ Manual Therapy Techniques
☒ ROM
☒ Neuromuscular Re-education

Instruct:
☒ Posture/Body Mechanics
☒ HEP

Additional Orders (specify):

21 EQUIPMENT INTERVENTIONS:

Assess:
☒ Equipment Needs
☒ Adaptive Equipment

Perform:
☐ W/C Measurements/Fittings
☐ Prosthetic/Orthotic Training
☐ Request HME

Instruct:
☒ Use of Assistive Devices/Orthotics
☐ Home use of HME ___
☐ Home use of CPM

Additional Orders (specify):

18A FUNCTIONAL LIMITATIONS:

☐ Amputation ☐ Contracture ☐ Hearing ☐ Endurance ☒ Ambulation ☐ Speech ☐ Legally Blind ☐ Paralysis ☐ Cognition ☒ Pain ☐ Vision ☐ Balance ☐ Other (specify):

P OM (M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
☐ 0 - No standardized assessment conducted
☐ 1 - Yes, and it does not indicate severe pain
☒ 2 - Yes, and it indicates severe pain

Comments

P OM (M1242) Frequency of Pain Interfering with patient's activity or movement:
☐ 0 - Patient has no pain
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☒ 4 - All of the time

Location: (B) ankles lap (R) 2° surgery
Onset Date: MD aware of pain [illegible]
Pain precipitated by: difficulties - husband spouts
Pain duration: MD knee at present - changing
History of pain management: rehab stay on 6/7/10
Current pain management & effectiveness:

Pain Rating: 10/10 ☒ Numeric ☐ FLACC ☐ Faces
LE Neuropathic pain rating: ___/10 ☒ NA

21 Pain Management Interventions: Assess/Perform/Instruct Pt/Cg:

	A	P	I
☒ Heat/Ice to (B) ankles q2hB x 30min	☒		☒
☐ TENS to ___	☐	☐	☐
☒ Activity Modification ___	☒	☒	☒
☐ Manual Therapy Techniques ___	☐	☐	☐

Assess/Perform/Instruct Pt/Cg:

	A	P	I
☒ Positioning ___	☒	☒	☒
☐ MIRE to ___ area for increase circulation and/or pain control for 30-45 minutes for ___ visits, effective ___	☐		
☐ Other: ___	☐	☐	☐

Comments provided ice packs/theraband to keep ice packs on — [illegible] at +40/min no how to use ice — [illegible] verbalize understanding

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Patient Name (Last, First) Brannon Mary Ann | Client No. 18847

INTEGUMENTARY STATUS

Wound #/ Location	Wound Type	Dimensions	Exudate	Wound Tissue Type	Surrounding Skin
1		L ______ cm W ______ cm D ______ cm Tunneling/Undermining - Location: ______ - ______ cm	Amount ______ Type ______ Color ______	Red - ______% Pink - ______% Yellow - ______% Black - ______% Other: ______ - ______%	______ margins, ______ cm Location ______
2		L ______ cm W ______ cm D ______ cm Tunneling/Undermining - Location: ______ - ______ cm	Amount ______ Type ______ Color ______	Red - ______% Pink - ______% Yellow - ______% Black - ______% Other: ______ - ______%	______ margins, ______ cm Location ______
TYPE: Lesion/ulcer Pressure ulcer: S1, S2, S3, S4 Incision w/staples or sutures Trauma wound Burn Incision, closed Other *(describe)*		LENGTH - Longest head to toe, in cm (to nearest 1/10th of a cm). WIDTH - Widest left to right, in cm (to nearest 1/10th of a cm). DEPTH - Too shallow to measure depth, use 'superficial' or ~0.1cm.	AMOUNT: None, Scant, Small, Medium, Large TYPE: Serous, Serosanguineous, Sanguineous, Purulent, Purulent w/foul odor COLOR: Yellow, Whitish, Green, Tan, Other: *(describe)*	WOUND TISSUE TYPE - KEY (must add up to 100%) Red - Healthy, often beefy-red, granulation tissue Pink - Viable tissue but not granulating, often smooth Yellow - Soft, necrotic tissue, may be loose or adherent (aka slough) Black - Hard, necrotic tissue, may be loose or adherent (aka eschar) Other - Describe any other tissue by color	SURROUNDING SKIN - KEY Margins - reddened, tender, warm, rash, macerated, closed edges, calloused, within normal limits (WNL), other *(describe)* cm - width in cm's extending out from the wound Located - use the clock-face to describe (ex: from 2 to 5 o'clock)

Additional Assessment findings: Surgical wound not assessed 2° non removable dressing

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK IN HOME CARE

NPO[1]: Nothing by mouth | IV[2]: Intravenously | TPN[3]: Total parenteral nutrition

	1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	1. Completely Limited: a. Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR b. Limited ability to feel pain over most of body.	2. Very Limited: a. Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR b. Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited: a. Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR b. Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	(circled) 4. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture	1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Often Moist: Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	(circled) 4. Rarely Moist: Skin is usually dry; linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	1. Bedfast: Confined to bed.	(circled) 2. Chairfast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of day in bed or chair.	4. Walks Frequently: Walks outside room twice a day and inside room at least once every 2 hours during waking hours.
MOBILITY Ability to change and control body position	1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance.	(circled) 2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited: Makes frequent though slight changes in body or extremity position independently.	4. No Limitation: Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern	1. Very Poor: a. Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR b. Is NPO[1] and/or maintained on clear liquids or IVs[2] for more than 5 days.	2. Probably Inadequate: a. Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR b. Receives less than optimum amount of liquid diet or tube feeding.	3. Adequate: a. Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR b. Is on a tube feeding or TPN[3] regimen which probably meets most of nutritional needs.	(circled) 4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION AND SHEAR	1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	(circled) 3. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

SCORE KEY: 15-18 = Mild Risk 13-14 = Moderate Risk 10-12 = High Risk ≤9 = Severe Risk

TOTAL SCORE 19

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P (M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

- ☐ 0 - No assessment conducted [Go to *M1306*]
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☒ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

Comments

(M1302) Does this patient have a Risk of Developing Pressure Ulcers?

☒ 0 - No ☐ 1 - Yes

Comments

(OM) (M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?

☒ 0 - No [Go to *M1322*] ☐ 1 - Yes

Comments

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INTEGUMENTARY STATUS (continued)

IRS OM **(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**
(Enter "0" if none; excludes Stage I pressure ulcers)

Stage Description - Unhealed Pressure Ulcers	Number Currently Present
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	☐
b. **Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.**	☐
c. **Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.**	☐
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	☐
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	☐
d.3 Unstageable: Suspected deep tissue injury in evolution.	☐

Comments

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" |___|___|.|___| (cm)

Comments

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length |___|___|.|___| (cm)

Comments

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area |___|___|.|___| (cm)

Comments

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:
- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

Comments

IRS OM **(M1322) Current Number of Stage I Pressure Ulcers:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.
- ☒ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

Comments

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
- ☐ **1 - Stage I**
- ☐ **2 - Stage II**
- ☐ **3 - Stage III**
- ☐ **4 - Stage IV**
- ☒ NA - No observable pressure ulcer or unhealed pressure ulcer

Comments

IRS **(M1330)** Does this patient have a **Stasis Ulcer?**
- ☒ 0 - No [Go to *M1340*]
- ☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- ☐ 2 - Yes, patient has observable stasis ulcers ONLY
- ☐ 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [Go to *M1340*]

Comments

IRS **(M1332) Current Number of (Observable) Stasis Ulcer(s):**
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

Comments

IRS **(M1334) Status of Most Problematic (Observable) Stasis Ulcer:**
- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ **2 - Early/partial granulation**
- ☐ **3 - Not healing**

Comments

OM **(M1340)** Does this patient have a **Surgical Wound?**
- ☐ 0 - No [Go to *M1350*]
- ☐ 1 - Yes, patient has at least one (observable) surgical wound
- ☒ 2 - Surgical wound known but not observable due to non-removable dressing [Go to *M1350*]

Comments

IRS OM **(M1342) Status of Most Problematic (Observable) Surgical Wound:**
- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ **2 - Early/partial granulation**
- ☐ **3 - Not healing**

Comments

OM **(M1350)** Does this patient have a **Skin Lesion** or **Open Wound,** excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?
- ☒ 0 - No
- ☐ 1 - Yes

Comments

21 **INTEGUMENTARY INTERVENTIONS:**

Assess:
- ☐ Skin Integrity
- ☐ Other: ____________

Perform:
- ☐ Staple Removal - Post Op day ________
- ☐ Suture Removal - Post Op day ________

Instruct:
- ☐ Pressure ulcer prevention measures

Additional Orders (specify): ____________

RESPIRATORY STATUS

OM 18A **(M1400)** When is the patient dyspneic or noticeably **Short of Breath?**
- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☒ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

Comments: SOB 2° anxiety/pain

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Patient Name (Last, First) Brannon Mary Ann | Client No. 18847

RESPIRATORY STATUS (continued)

(M1410) Respiratory Treatments utilized at home: *(Mark all that apply.)*
☐ 1 - Oxygen (intermittent or continuous) ☐ 3 - Continuous/Bi-level positive airway pressure
☐ 2 - Ventilator (continually or at night) ☒ 4 - None of the above

HISTORY OF: ☐ Asthma ☐ Pneumonia ☐ Cough ☐ Emphysema ☐ TB ☐ Bronchitis ☐ Pleurisy ☐ Sputum ☐ Other: ______

Comments

21 Respiratory Interventions: Assess/Perform/Instruct Pt/Cg: A P I
☐ Chest Physical Therapy ☐
☐ O_2 Sat ☐
☐ Breathing Techniques ☐ ☐ ☐

Additional Orders (specify): ______

Comments

CARDIAC STATUS

VITAL SIGNS: PULSE: ☐ Apical ______ (Reg) (Irreg)
☒ Radial 84 (Reg) (Irreg)
TEMP.: 98.2 RESP.: 16

B/P: Lying / Sitting / Standing
L ______
R ______ 118/86 ______
O_2 Sat: ______

Patient's Height: ______ ☐ Actual ☐ Reported
Weight: ______ ☐ Actual ☐ Reported

21 Notify Physician if temp > ______ < ______ Blood Pressure: Systolic > ______ < ______ Diastolic > ______ < ______ Pulse Rate > ______ < ______
Respiratory Rate > ______ or < ______ O_2 Sat less than ______

Cardiovascular: (History of:)
☐ Palpitations ☐ Dyspnea on Exertion ☐ BP Problems ☐ Edema
☐ Claudication ☐ Chest Pain ☐ Paroxysmal Nocturnal Dyspnea ☐ Other (specify):
☑ Easily Fatigued ☐ Cyanosis ☐ Orthopnea (# of pillows used: ______)

Comments

Testing performed (required for Senior Health and Cardiopulmonary):
RPE: ______ Scale used (i.e., borg): ______
Pre VS P: ______ B/P: ______ R: ______ ☐ 2 ☐ 3 ☐ 6 Minute Walk Test: ______ feet Post VS P: ______ B/P: ______ R: ______

URINARY STATUS

OM (M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days?
☒ 0 - No ☐ 1 - Yes ☐ NA - Patient on prophylactic treatment ☐ UK - Unknown

Comments

NRS OM 18A (M1610) Urinary Incontinence or Urinary Catheter Presence:
☒ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to *M1620*]
☐ 1 - Patient is incontinent
☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to *M1620*]

Urinary Ostomy (Type):
Supplies Used:
Comments

OM (M1615) When does Urinary Incontinence occur?
☐ 0 - Timed-voiding defers incontinence ☐ 3 - During the day only
☐ 1 - Occasional stress incontinence ☐ 4 - During the day and night
☐ 2 - During the night only

Comments

GI STATUS

ENDOCRINE ☑ WNL
☐ Polyuria/Polydipsia/Polyphagia ☐ Thyroid Disease
☐ Neuropathy/Radiculopathy ☐ Diabetes
☐ Blood Sugar Glucometer Use ☐ Insulin Dependent? How Long? ______
☐ Oral Hypoglycemic Agent Most recent FBS ______
LBM ______ Usual Frequency ______ ☐ Diarrhea ☐ Constipation: ☐ Chronic ☐ Acute

Comments

NRS OM 18A (M1620) Bowel Incontinence Frequency:
☒ 0 - Very rarely or never has bowel incontinence ☐ 4 - On a daily basis
☐ 1 - Less than once weekly ☐ 5 - More often than once daily
☐ 2 - One to three times weekly ☐ NA - Patient has ostomy for bowel elimination
☐ 3 - Four to six times weekly ☐ UK - Unknown

Comments

NRS (M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?
☒ 0 - Patient does not have an ostomy for bowel elimination.
☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Ostomy (Type):
Equipment Used (Size, Type):
Comments

NEURO/EMOTIONAL/BEHAVIORAL STATUS

OM (M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
☒ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Comments

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NEURO/EMOTIONAL/BEHAVIORAL STATUS (continued)

OM (M1710) When Confused (Reported or Observed Within the Last 14 Days):
- [x] 0 - Never
- [ ] 1 - In new or complex situations only
- [ ] 2 - On awakening or at night only
- [ ] 3 - During the day and evening, but not constantly
- [ ] 4 - Constantly
- [ ] NA - Patient nonresponsive

Comments

OM (M1720) When Anxious (Reported or Observed Within the Last 14 Days):
- [ ] 0 - None of the time
- [x] 1 - Less often than daily
- [ ] 2 - Daily, but not constantly
- [ ] 3 - All of the time
- [ ] NA - Patient nonresponsive

Comments

P OM (M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?
- [ ] 0 - No
- [x] 1 - Yes, patient was screened using the PHQ-2©* scale. *(Instructions for this two-question tool; Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")*

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	[x] 0	[ ] 1	[ ] 2	[ ] 3	[ ] NA
b) Feeling down, depressed, or hopeless?	[ ] 0	[x] 1	[ ] 2	[ ] 3	[ ] NA

- [x] Difficulty sleeping: needed
- [x] Change in appetite: teaching

Comments: to get into bedroom ↓ appetite 20 pa

- [ ] 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- [ ] 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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***For a score of 3 or higher, the Physician should be notified.**

18A (M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): *(Mark all that apply.)*
- [ ] 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
- [ ] 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- [ ] 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- [ ] 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- [ ] 6 - Delusional, hallucinatory, or paranoid behavior
- [x] 7 - None of the above behaviors demonstrated

Comments

OM (M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
- [x] 0 - Never
- [ ] 1 - Less than once a month
- [ ] 2 - Once a month
- [ ] 3 - Several times each month
- [ ] 4 - Several times a week
- [ ] 5 - At least daily

Comments

OM (M1750) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?
- [x] 0 - No
- [ ] 1 - Yes

Comments

19 MENTAL STATUS:
- [x] Oriented: [x] Person [x] Place [x] Time
- [ ] Depressed
- [ ] Disoriented
- [ ] Comatose
- [ ] Forgetful
- [ ] Agitated
- [ ] Lethargic
- [ ] Other: ____

Additional Orders (specify): ____

ADL / IADLs

OM (M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
- [ ] 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- [ ] 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- [x] 2 - Someone must assist the patient to groom self.
- [ ] 3 - Patient depends entirely upon someone else for grooming needs.

Comments

OM (M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
- [ ] 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- [ ] 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- [x] 2 - Someone must help the patient put on upper body clothing.
- [ ] 3 - Patient depends entirely upon another person to dress the upper body.

Comments

OM (M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
- [ ] 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- [ ] 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- [x] 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- [ ] 3 - Patient depends entirely upon another person to dress lower body.

Comments

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Patient Name (Last, First) Brannon Mary Ann | Client No. 18847

ADL / IADLs (continued)

(OM) (M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

- ☐ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- ☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- ☒ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Comments: pt can't transfer to shower

(OM) (M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- ☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.
- ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- ☒ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- ☐ 4 - Is totally dependent in toileting.

Comments

(OM) (M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- ☐ 0 - Able to manage toileting hygiene and clothing management without assistance.
- ☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- ☒ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- ☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

Comments

(OM) (M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- ☐ 0 - Able to independently transfer.
- ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- ☒ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

TRANSFERS: ☐ N/A

KEY: 7 = Total Independent 6 = Adapted Independent 5 = Supervision 4 = Minimum Assist 3 = Moderate Assist 2 = Maximum Assist 1 = Total Assist

☒ Bed Mobility 2	☒ Chair 2	☐ Auto ____
☒ In/Out of Bed 2	☒ Commode/Toilet 2	☐ Floor ____
☒ Sit to Stand 2	☒ Tub/Shower 2	☐ ____

Describe:

Comments

(OM) (M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☒ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

GAIT: ☐ N/A

KEY: 7 = Total Independent 6 = Adapted Independent 5 = Supervision 4 = Minimum Assist 3 = Moderate Assist 2 = Maximum Assist 1 = Total Assist

SURFACE		DEVICE		BALANCE
☒ Level	1	☒ FWW	1	☐ Dynamic
☐ Curbs		☐ SPC		☐ Static
☒ Uneven	1	☐ WC		☐ Sit
☐ Ramps		☐ None		☐ Stand
☒ Stairs	1	☐ Crutches		☐ Grade ____
☐ ____		☐ ____		

☒ Distance non amb currently - ☐ Number of Stairs only transfers

GAIT ANALYSIS - *(Wt. Bear, Fall Risk, Describe)*:

Propels W/C On: ☐ Level Surface ☐ Uneven Surface ☐ Ramps
W/C Management: ☐ Brakes ☐ Foot/Leg Rests

Comments

(OM) (M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☒ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- ☐ 5 - Unable to take in nutrients orally or by tube feeding.

Comments

(OM) (M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ☒ 2 - Unable to prepare any light meals or reheat any delivered meals.

Comments

(OM) (M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- ☒ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ☐ 5 - Totally unable to use the telephone.
- ☐ NA - Patient does not have a telephone.

Comments

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ADL / IADLs (continued)

21 FUNCTIONAL INTERVENTIONS:

Assess:
- [x] Bed Mobility
- [x] Transfers
- [x] Wheelchair use
- [x] Gait on Stairs/Uneven Surfaces
- [x] Gait on Level Surfaces
- [ ] Weight Bearing Status

Perform:
- [x] Functional Mobility Training
- [x] Bed Mobility
- [x] Transfer Training
- [ ] Wheelchair Training
- [x] Gait Training

Instruct:
- [ ] Positioning
- [ ] Energy Conservation
- [ ] NWB on ______ extremity
- [ ] TDWB on ______ extremity
- [ ] PWB on ______ extremity
- [ ] WBAT on ______ extremity
- [ ] FWB on ______ extremity

Additional Orders (specify): ______

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.
(Check only ONE box in each row.)

Functional Area	Independent	Needed Some Help	Dependent	Comments
a. Self-Care (e.g., grooming, dressing, and bathing)	[x] 0	[ ] 1	[ ] 2	
b. Ambulation	[x] 0	[ ] 1	[ ] 2	
c. Transfer	[x] 0	[ ] 1	[ ] 2	
d. Household tasks (e.g., light meal preparation, laundry, shopping)	[x] 0	[ ] 1	[ ] 2	

Fall Risk Assessment	*Assess one point for each core element "Yes"*	Points
Age 65+		0
Diagnosis (3 or more co-existing)	Assess for hypotension.	0
Prior history of falls within 3 months	Fall Definition, "An unintentional change in position resulting in coming to rest on the ground or at a lower level."	1
Incontinence	Inability to make it to the bathroom or commode in a timely manner. Includes frequency, urgency, and/or nocturia.	0
Visual impairment	Includes macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	0
Impaired functional mobility	May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	1
Environmental hazards	May include poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	1
Poly Pharmacy (4 or more prescriptions)	Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	1
Pain affecting level of function	Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	1
Cognitive impairment	Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	0
A score of 4 or more is considered at risk for falling	TOTAL	5

Most recent fall: [x] <3 Months [ ] 4-6 Months [ ] 7-12 Months [ ] >1 year [ ] No fall

TUG Score: ______ seconds

Reasons TUG Not Performed:
- [x] Limiting orthopedic conditions (weight bearing restrictions or other precautions)
- [ ] Known need for assistance with ambulation
- [ ] Inability to follow or remember simple commands
- [ ] Bed-bound status
- [ ] Other (explain): ______

Comments

P **(M1910)** Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
- [ ] 0 - No multi-factor falls risk assessment conducted.
- [ ] 1 - Yes, and it does not indicate a risk for falls.
- [x] 2 - Yes, and it indicates a risk for falls.

21 Fall Prevention Interventions: Assess/Perform/Instruct Pt/Cg: A P I
- [x] Fall Prevention [x] [x] [x]

18A Homebound Status (Measurable Qualifier)

Based on assessment information, is this patient homebound? [x] Yes [ ] No

Check all that apply and provide brief example/explanation
- [x] Considerable and taxing effort to leave home Req. max @ all mobility
- [ ] Illness/injury restricts ability to leave home ______
- [ ] Cognitive impairments (specify): ______
- [ ] Psychiatric illness manifested in refusal to leave home ______
- [ ] Psychiatric illness manifested in unsafe to leave home ______
- [ ] Specify effort needed to leave home ______
- [ ] Describe impact any departure has on patient ______

NUTRITIONAL SCREENING	Yes
Patient has illness or condition that requires a change in the kind/amount of food eaten	2
Patient has fewer than 2 meals/day	(2)
Patient eats few fruits and vegetables or milk products	2
Patient consumes 3 or more drinks of alcohol almost every day	2
Patient has tooth or mouth problems that make it hard to eat	2
Patient does not have the resources to purchase needed food	3
Patient takes 3 or more medications per day	(1)
Patient has lost or gained > 10 lbs. in the past 6 months without dieting	1
There is no reliable caregiver to shop, cook, and/or feed patient if unable to do independently	1
Patient has inadequate/improper food storage/cooking facilities	2
Patient has significant memory loss and/or depression	2
Patient has been receiving enteral or parenteral nutrition	3
Patient has open wounds	3
Total Nutritional Score	3

Nutritional Screening:
(9) or more = high risk; potential referral to MSW or dietitian
(6-8) = moderate risk; provide education/further assessment

Comments

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Patient Name (Last, First) Brannon Mary Ann

Client No. 17847

ADL / IADLs (continued)

16 NUTRITIONAL REQUIREMENTS NEW OR CHANGED: ☒ Regular

☐ ______ Sodium Diet ☐ Hi ☐ Low Protein ☐ Heart Healthy Low Fat
☐ ______ Calorie ADA Diet ☐ Hi ☐ Low Carbohydrates ☐ No Added Salt
☐ Bland Diet ☐ No Concentrated Sweets

☐ Enteral Feeding ______ Amount ______ mL/day
Pump Type: ______
☐ Mechanical (Soft, Hi-Fiber, etc.) ☐ NG Tube
☐ Supplement ☐ PEG Tube
☐ Other (specify): ______ ☐ ______ Tube

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

☐ 0 - Not assessed/reviewed [Go to *M2010*]
☐ 1 - No problems found during review [Go to *M2010*]
☒ 2 - Problems found during review
☐ NA - Patient is not taking any medications [Go to *M2040*]

Comments

OM (M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

☒ 0 - No ☐ 1 - Yes

Comments Cm for MD

P OM (M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No
☒ 1 - Yes
☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

Comments Ongoing educ re Coumadin at ea visit

OM (M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

☒ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
☐ 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
☐ 3 - Unable to take medication unless administered by another person.
☐ NA - No oral medications prescribed.

Comments

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection.
☐ 3 - Unable to take injectable medication unless administered by another person.
☒ NA - No injectable medications prescribed.

Comments

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. *(Check only ONE box in each row.)*

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☒ 0	☐ 1	☐ 2	☐ NA
b. Injectable medications	☐ 0	☐ 1	☐ 2	☒ NA

Comments

CARE MANAGEMENT

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. *(Check only ONE box in each row.)*

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	☐ 0	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ 0	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
c. Medication administration (e.g., oral, inhaled or injectable)	☐ 0	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
d. Medical procedures/treatments (e.g., changing wound dressing)	☒ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	☒ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. Supervision and safety (e.g., due to cognitive impairment)	☐ 0	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	☒ 0 (crossed out, "error" [initials])	☒ 1 (crossed out, "error" [initials])	☐ 2	☐ 3	☒ 4	☐ 5

Comments

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CARE MANAGEMENT (continued)

(M2110) How often does the patient receive **ADL** or **IADL** assistance from any caregiver(s) (other than home health agency staff)?

- [x] 1 - At least daily
- [x] 2 - Three or more times per week
- [ ] 3 - One to two times per week
- [ ] 4 - Received, but less often than weekly
- [ ] 5 - No assistance received
- [ ] UK - Unknown

Comments

THERAPY NEED AND PLAN OF CARE

(OM) **(M2200) Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)

[12] Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

- [ ] NA - Not Applicable: No case mix group defined by this assessment.

P (OM) **(M2250) Plan of Care Synopsis:** *(Check only ONE box in each row.)* Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐ 0	☐ 1	☒ NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☒ NA	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	☐ 0	☒ 1	☐ NA	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☒ NA	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐ 0	☒ 1	☐ NA	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☒ NA	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐ 0	☐ 1	☒ NA	Patient has no pressure ulcers with need for moist wound healing

Comments

DME AND SUPPLIES

RS 14 DME:

- [x] Bedside Commode
- [ ] Cane
- [ ] Elevated Toilet Seat
- [ ] Grab Bars
- [ ] Hospital Bed
- [ ] Tub Bench
- [x] Wheelchair
- [x] Walker
- [ ] Exercise Putty
- [ ] Exercise Band
- [ ] Staple Remover
- [ ] Steri Strips
- [ ] Other:

Safety measures/additional equipment recommended to protect patient from injury: pt needs @ day 1+2 c̄ commode— able to do c̄ (S) by day 3

Specific safety issues discussed:

Patient/Family able to use all equipment/supplies safely? ☐ Yes ☒ No If No, specify: not initially - should have (S) but ~~spo~~ spouse ∅ present

Comments

21 ORDERS FOR FREQUENCY/DURATION OF SERVICES

- [x] Physical Therapy Visit Frequency/Duration 5w2 2w1
- [ ] HHA Visit Frequency/Duration ______ to assist w/personal care/ADLs/light housekeeping as needed
- [x] OT Eval (specify): 1w1 to eval + Rx
- [ ] ST Eval (specify):
- [ ] MSW Eval (specify):
- [x] Other: PT/INR to be done ~~Mon/Thurs~~ every … via fingerstick or venipuncture
- [ ] Implement and Instruct Standard Precautions/Infection Control
- [ ] Dietitian evaluation *Refer to Page 11 Nutritional Screening to determine need for further Nutrition Assessment by qualified H.C. Professional.*
- [x] May take orders from primary M.D

22 REHABILITATION POTENTIAL/DISCHARGE PLANS

- [x] Rehabilitation potential to achieve goals: ☐ Good ☒ Fair ☐ Poor Comments:

See Protocols, specify: ankle protocol, fall prevention

Discharge Plans

- [x] Patient to be discharged when skilled care no longer needed
- [ ] Other (specify):
- [ ] Patient to be discharged to the care of: ☐ Self ☐ Caregiver ☐ Other:
- [ ] Discharge plan initiated
- [x] Discharge to Outpatient Physical Therapy as needed
- [ ] No plans to discharge (patient requires ongoing care)

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Patient Name (Last, First) Brannan Mary Ann | Client No. 18847

SKILLED SERVICES/SIGNIFICANT CLINICAL FINDINGS

SIGNIFICANT CLINICAL FINDINGS: Pt presents c̄ significant limitations in fx'l mobility 2° NWB (R) ankle, (L) ankle sprain + pain. Pt initially was going to return to rehab but after education re pain control, ice, teaching transfers + positioning at initial eval pt ~~was~~ able to remain at home c̄ support from family.

SKILLED SERVICES PROVIDED THIS VISIT: Educ pt re ice, transfers, positioning, pain mngmt, coumadin precautions

THERAPEUTIC EXERCISE: ☐ NA

☐ PROM ☐ PNF ☐ Sensation/Proprio
☐ AAROM ☒ Balance ☐ Gaze Stabilization
☐ AROM ☐ Coordination
☐ ARROM ☒ Muscle Re-Education

Describe: taught mostly positioning relief to allow it-touch c̄ foot on ground to relax (R) hip/knee mm.

SKILLED TEACHING / PATIENT RESPONSE

SKILLED TEACHING: KEY: 7 = Total Independent, 6 = Adapted Independent, 5 = Supervision, 4 = Minimum Direction, 3 = Moderate Direction, 2 = Maximum Direction, 1 = Total Direction

TO PATIENT (pt) or CAREGIVER (Cg) and RESPONSE ☐ NA

Item	pt	Cg	Item	pt	Cg	Item	pt	Cg	Item	pt	Cg
☒ Gait	4		☒ Safe Handling Techniques	4	5	☐ Positioning			☐ ADLs		
☐ Equipment Use			☐ Home Program introduction			☐ Pressure Ulcer Prevention			☐ s/s infection		
☒ Ortho. Precautions	4	5	☐ Activity Precautions			☐ Modify Environment			☐ DC Plan		
☐ Body Mechanics			☐ Energy Conservation			☒ Pain Management	4	5	☒ Transfers	4	5
☒ Home Safety	4	5	☐ W/C Management			☐ Pulmonary Management			☐ s/s DVT		
☐ Fall Prevention			☐ Prosthetic/Orthotics Mgmt.			☐ Edema Reduction			☐		

CONCLUSION/IMPRESSIONS FROM ASSESSMENT: Pt presents s/p (R) ankle ORIF, req PT for teaching transfers, gait, pain mngmt, positioning, + strength to manage at home fairly (I). Pt is motivated to do PT to stay at home

☒ POC discussed with (Patient) Caregiver ☒ (Patient)/Caregiver agreed with plan: yes

Ordering Physician Name: Dr. Sean Wilson

Physician contacted with assessment findings and approved orders, discipline and frequency ☐ PHQ-2 results ☒ Yes, Date: 6/7/10

☒ Gait Training ☒ HEP ☒ Safety Recommendation ☒ OTHER: PT/INR via finger stick or venipuncture
☒ Transfer Training ☒ Therapeutic Exercise ☒ Equipment Recommendation

Therapist Name: (First, MI, Last) Print: Anne Coffman	HHA USE ONLY	Checked By: RMT, Date: 6-16-10	Entered By: lms, Date: 6-15-10	Transmitted By, Date:
Therapist Signature and Date: ACoffman PT MSGS 6/9/10				

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Patient Name (last, first): Brannon, Maryann Patient Number: 18847

SIGNIFICANT CLINICAL FINDINGS/SKILLED INTERVENTIONS PROVIDED:

Pt is S/P ORIF (R) ankle, NWB (R) LE + sprain (L) ankle. Functional mobility skills training provided to maximize function, safety, + ortho status. Pt initially felt she was performing at a sufficient functional level but then determined that she would require (A) to achieve (I) c̄ shower, currently Min (A). OT goal is to provide training for safe (I) shower performance. Pt would benefit from application of below interventions to address deficit areas + maximize function + safety.

REHAB POTENTIAL TO ACHIEVE GOALS: ☑GOOD ☐FAIR ☐POOR

☐**CARE PROTOCOLS**

☑Evaluation ☐Energy Conservation ☐Neuromusculoskeletal (strength/endurance/ROM/posture/reflex)
☑ADL Training/Selfcares ☐Joint Protection ☐Sensory Treatment ☐Orthototics/Splinting
☐Home Program ☐Muscle Reeducation ☑Body Mechanics ☐Adaptive Equipment
☑Patient/Caregiver Education ☑Trunk Control/Balance ☐Perceptual Motor Training ☐Work Simplification
☐Fine Motor Training ☑Safety Training ☐Edema Management ☐Environmental Modification
☑Adaptive Environment Recommendations and Training ☐Seating/Positioning ☐Therapeutic Tasks
☑Functional Mobility Training

Comments: Pt performed shower c̄ sister prior to OT eval c̄ Min (A) using commode - HHSH c̄ (R) LE wrapped in plastic bag secured c̄ rubber band + placed outside of shower. OT to f/u R/T shower status + physician recommendations c̄ S/P (R) ankle ORIF, staples not yet removed. If pt shower to be placed ON HOLD, pt would benefit from training to achieve (I) c̄ sponge bathing + hair washing within NWB (R) LE status.

DISCHARGE PLANS:

☐Discharge plan initiated
☐Patient to be discharged with skilled care no longer needed ☐Other (specify)
☑Patient to be discharged to the care of: ☐Self ☐Caregiver ☐Other
☐No plans to discharge (patient requires ongoing care)

☐Changes in POC discussed with Patient/Caregiver ☐Patient/Caregiver agreed with plan: ☐See Documentation Addendum
Contacted/conference with: SN PT PTA OT SLP MSS HHA Other (circle) Name: Date/Time:
Response:
Ordering Physician's Name: Dr Wilson
Physician contacted and approved orders, discipline and frequency/duration ☑Yes ☐No Verbal SOC Date: 1/18/10

Therapist Signature: Michelle [signature], OT Date: 1/18/10

OFFICE M.I.

PATIENT NAME Mary Ann Brannon PATIENT DOB 9/29/51 PATIENT # 18847

PHYSICIAN NAME Dr Wilson PHYSICIAN PHONE #

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP 19474 W. N. Ave Brookfield WI 53040

COMMUNICATION WITH PHYSICIAN

Pt is progressing well c P.T. and OT. Both therapies may extend depending on progress

Clinician Signature: [signature] PT Date: 6/16/10

PHYSICIAN'S INTERIM ORDER

Dear ______________
This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: ______________ **Date Interim Order to be Discontinued [if known]:** ______________

Change Primary DX to:

Change Pertinent DX to:

Orders: Pain rated 7/10 on (R) 0/10 on (L)

no ROM done. (R) LE left intact

Gait: Pt now able to hop 25' c FWW following weight bearing restrictions CGA. No gait c exception of P.T.

Transfers (I) to/from commode w/c's at times for safety

Will cont per direction of MD.

21050

Clinician Signature ▶ [signature] PT **Date** 6/16/10

Reviewed by: (Signature/Title) ▶ **Date**

Physician Signature ▶ [signature] **Date** 6/16/10

White – Clinical Record
Yellow – Physician

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

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Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

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.
394584069A	060510	From: 060510 To: 080310	0247-18847	527207

6. Patient's Name and Address
BRANNON MARYANN
2092 SOUTH 102ND STREET
WEST ALLIS WI
53227 414-731-1563

7. Provider's Name, Address and Telephone Number
GENTIVA HEALTH SVC 414-257-1156
10400 W INNOVATION CTL# 15298
SUITE 320 6/16/10
WAUWATOSA WI 53226

8. Date of Birth: 092951 **9. Sex** [ ] M [XX] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
WARFARIN SODIUM 2MG 2 TABS DAILY PO N
IBUPROFEN 600MG 1 TAB 2X/DAY PO N
OXYCODONE 10MG 1 TAB 2X/DAY PO N
OXYCODONE/APAP 5MG/325MG 1-2 TABS N
PO EVERY 4-6 HRS PRN
POLYETHYLENE GLYCOL 3350 NF POWDER N
17G MIXED IN 8 OZ OF FLUID
DRINK PO 1X/DAY

11. ICD-9-CM	Principal Diagnosis	Date
V5789	REHABILITATION PROC NEC	060510

12. ICD-9-CM	Surgical Procedure	Date
7936	OP RED-INT FIX TIB/FIBU	060310

13. ICD-9-CM	Other Pertinent Diagnoses	Date
V5416	AFTERCARE HEALING-LEG L	060510
84500	SPRAIN OF ANKLE NOS	060310
49390	ASTHMA W/O STATUS ASTHM	060108

SEE 487

14. DME and Supplies SEE 487
Bedside Commode,

15. Safety Measures: SEE 487
Anticoagulant Precautions,

16. Nutritional Req. Regular Diet

17. Allergies: SEE 487

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

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

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

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

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

TREATMENT WEEK: Saturday - Friday
EFFECTIVE ON OR AFTER: 6/05/10
PT 5 X WK X 2 WKS , 2 X WK X 1 WKS
HOME ENVIRONMENT/SAFETY INTERVENTIONS:
Assess: Architectural Barriers, Patient Safety Awareness,
Instruct: Home Safety Measures,

MUSCULOSKELETAL INTERVENTIONS:
Assess: Balance/Posture/Coordination, Functional Activity Tolerance,
Perform: Therapeutic Exercise, Manual Therapy Technique, ROM,
Neuromuscular Re-Education,
Instruct: Posture/Body/Mechanics, HEP,

SEE 487

22. Goals/Rehabilitation Potential/Discharge Plans
PT GOALS: Patient will present with: degrees; increased strength of the R/L LE from 3- to 3+ grade by 6/25/10.

SEE 487

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Rosalinda M. Tavelara 6/16/10

25. Date HHA Received Signed POT

24. Physician's Name and Address
NPI# 1114917812
WILSON SEAN 262-780-4400
19474 WEST NORTH AVENUE
SUITE 201 U72035
BROOKFIELD WI 53040

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
[signature] 6/18/10

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.

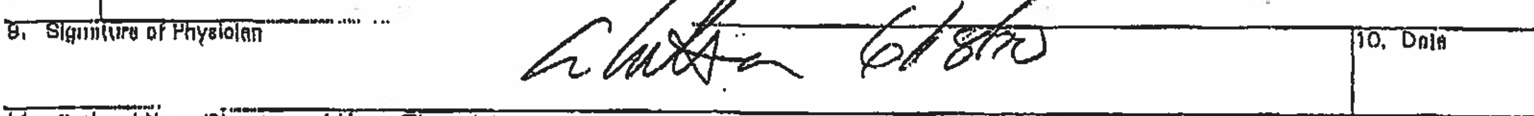
ADDENDUM TO: PLAN OF TREATMENT [X] MEDICAL UPDATE [ ]

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
394584069A	060510	From: 060510 To: 080310	0247-18847	527207

6. Patient's Name		7. Provider Name	
BRANNON	MARYANN	GENTIVA HEALTH SVC	6/16/10

8. Item No.	
	Locator 13 - Other Pertinent Diagnoses
13	~~V5861 LONG-TERM USE ANTICOAGUL 060510~~
13	~~V5883 THERAPEUTIC DRUG MONITOR 060510~~
	Medications: Dose/Frequency/Route (N)ew (C)hanged
10	NICOTINE 14MG APPLY DAILY X 2 WKS
10	MULTIVITAMIN 1 TAB DAILY PO
10	BENEFIBER IT INTO 8 OZ LIQUID PO DAILY N
10	NASONEX 50MCG 1 SPRAY EACH NOSTRIL
10	2X/DAY
10	OFLOXACIN 0.3% SOLN 3 DROPS INTO
10	AFFECTED EAR PRN
10	NEXIUM 40MG 1 CAP DAILY PO
10	SINGULAIR 10MG 1 TAB DAILY PO
10	VENTOLIN HFA 90MCG 1-2 PUFFS EVERY
10	6 HRS PRN
10	ADVAIR 250/50MCG 1 INHALATION PO DAILY
10	ALBUTEROL SULFATE SOLN 0.083% 2.5MG/ML
10	1 VIAL PER NEBULIZER DAILY
	DME and Supplies
14	Wheelchair,
14	Walker,
	Safety Measures
15	Environmental,
15	Bathroom,
	Allergies
17	NUBANE, KEFLEX, ASPIRIN,
17	DANON, CODEINE, LATEX
	Functional Limitations/Activities Permitted
18	Pain,
18	ACTIVITIES PERMITTED:
18	Precautions -- NMB right LE
18	HOMEBOUND STATUS: Yes
18	Considerable and taxing effort to leave home -- requires maximum
18	assistance all mobility
	Orders for Discipline and Treatments
21	EQUIPMENT INTERVENTIONS:
21	Assess: Equipment Needs, Adaptive Equipment,
21	Instruct: Use of Assistive Devices/Orthotics,
21	
21	PAIN MANAGEMENT INTERVENTIONS:
21	Assess/Instruct: Ice to both ankles every 2 hours x 30 minutes

9. Signature of Physician



10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Form HCFA-487 (C4) (4-87)
780-0007 (4-ply)

OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT ☐ MEDICAL UPDATE

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
394584069A	060510	From: 060510 To: 080310	0247-18847	527207

6. Patient's Name		7. Provider Name	
BRANNON	MARYANN	GENTIVA HEALTH SVC	6/16/10

8. Item No.

Assess/Perform/Instruct: Activity Modification, Positioning,

21 FUNCTIONAL INTERVENTIONS:
21 Assess: Bed Mobility, Wheelchair use, Gait on Level Surface, Transfers,
21 Perform: Functional Mobility Training, Transfer Training, Gait
21 Training, Bed Mobility, Wheelchair Training,
21
21 FALL PREVENTION INTERVENTIONS:
21 Assess/Perform/Instruct: Fall Prevention,
21
21 OT Eval: 1w1 to eval and treat
21
21 PT/INR to be done via fingerstick or venipuncture
21
21 May take orders from: primary MD

EFFECTIVE ON OR AFTER: 6/05/10

OT 2 X WK X 2 WKS ; 1 X WK X 1 WKS

21 SKILLED ASSESSMENT:
21 Neuro/Musculo/Skeletal--ROM; strength; visual perceptual; sensation;
21 cognition; pain; righting/equilibrium responses; skin integrity
21 Functional Status--Grooming/personal hygiene; dressing; bathing;
21 toileting; meal preparation; homemaking; functional mobility;
21 functional transfers
21 Home Environment/Safety--Patient/caregiver knowledge; safety measures
21 Psycho-Social--Family roles/interaction
21
21 SKILLED TREATMENT:
21 Functional/Strengthening/Re-ed Exercises using ther ex, ther activity,
21 NM re-ed
21 Functional ADL Training--Dressing training; bathing training; toileting
21 training
21
21 SKILLED INSTRUCTION:
21 ADL techniques; functional application of body mechanics in ADLs;
21 positioning; safety measures; instruct/reinforce orthopedic
21 precautions; D/C teaching

Goals/Rehabilitation Potential/Discharge Plans

22 Transfers/Mobility will improve to maximum potential with the least
22 level of assistance: transfer supine to/from sit with independence;
22 transfer sit to/from stand with independence by 6/25/10.
22
22 Patient will ambulate functional distances: on even surfaces 50 feet
22 with supervision using w/w by 6/25/10.
22

9. Signature of Physician 6/18/10 | 10. Date

11. Optional Name/Signature of Nurse/Therapist | 12. Date

Form HCFA-487 (C4) (4-87)
790-0067 (4-ply)

OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT / MEDICAL UPDATE

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
394584069A	060510	From: 060510 To: 080310	0247-18847	527207

6. Patient's Name.		7. Provider Name	
BRANNON	MARYANN	GENTIVA HEALTH SVC	6/16/10

8. Item No.

22 Pain level will be improved to 3 on a 0-10 pain scale as determined in consultation with the patient to maximize functional ability by verbalizing/demonstrating: medication management, use of alternative pain relief measures by 6/25/10.

22 Patient will be independent with a comprehensive Home Exercise Program by 6/25/10.

22 Patient will demonstrate ability to safely perform ADLs/IADLs and routine household tasks or alternate resources identified by 6/25/10.

22 Patient/caregiver will demonstrate/verbalize awareness and strategies to reduce risk of falls, to prevent/minimize injury from a fall, and/or to reduce risk for repeat fall, and to reduce the risk for an acute care hospitalization. Patient/caregiver checks home for safety and makes an improvement plan to successfully modify/eliminate home hazards. Documenting and reporting falls, circumstances involved, and plan for how to get up/get help. Modification of daily routines so that frequently used items are within safe reach to avoid leaning too far forward, reaching overhead, stooping down, and/or carrying bulky items. Appropriate and correct use of walking aids and/or other devices/equipment such as bedside commode, tub/shower bench, and/or grab bars by 6/25/10.

22 Patient will improve muscle strength, transfer ability, balance, and/or gait pattern. Patient/caregiver will understand benefits of exercise as an effective way to reduce fall risk. Mobility will improve (i.e., getting up, walking, turning) to maximum potential with the least level of assistance by 6/25/10.

22 Patient/caregiver will verbalize understanding of the effects of sudden position changes (i.e. dizziness, lightheadedness). Patient/caregiver will understand/demonstrate safety behaviors when patient gets up from a lying or from sitting position (i.e., moving slowly, using assistive devices, and/or having assistance) by 6/25/10.
OT GOALS: Using energy conservation and work simplification techniques the patientwill demonstrate: upper body bathing with no assist; lower body bathing with no assist by 6/25/10.

22 Transfers will improve to maximum potential with the least level of assistance: transfer in/out of shower/tub with no assist using good safety by 6/25/10.

22 Patient will demonstrate adherence with safety precautions with ADLs by 6/25/10.

9. Signature of Physician [signature] 6/18/10

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Form HCFA-487 (C4) (4-87)
780-0007 (4-ply)

4. PHYSICIAN

Department of Health and Human Services
Health Care Financing Administration

OMB No. 0938-0357

ADDENDUM TO: [XX] PLAN OF TREATMENT [ ] MEDICAL UPDATE

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
394584069A	060510	From: 060510 To: 080310	0247-18847	527207

6. Patient's Name.		7. Provider Name	
BRANNON	MARYANN	GENTIVA HEALTH SVC	6/16/10

8. Item No.	
22	Patient will demonstrate ability to safely perform ADLs/IADLs and
22	routine household tasks or alternate resources identified by 6/25/10
22	
22	REHABILITATION POTENTIAL:
22	Rehabilitation potential for goal achievements: Fair,
22	See Protocols, Specify: Ankle protocol, Fall Prevention
22	
22	DISCHARGE PLANS:
22	Patient to be discharged when skilled care no longer needed,
22	Discharge to Outpatient Therapy, as needed

9. Signature of Physician

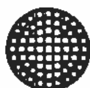
10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Form HCFA-487 (C4) (4-87)
790-0087 (4-ply)

4. PHYSICIAN



GENTIVA®

orthopedics

PATIENT PROGRESS REPORT

(Circle one) PT OT

Physician	Dr Wilson	Diagnosis/ Procedure	(L) ankle sprain/ (R) ankle fx/ORIF
Patient Name	Mary Ann Brannon	DOB 9-29-51	Patient # 18847
Patient Comments	Pt wants to know if she'll be able to walk normally again, if she'll need a brace long term. Can she do regular activities again in the future?	Pain (0-10) Scale	0/10
Observation	Pain under control but fx'lly still limited, weak, unable to ambulate (I) yet		
ROM / Strength	(L) ankle beginning Aromex - no resistence yet (L) knee hip 3+/5 - still quite weak + difficulty c̄ weight bearing c̄ gait. Beginning resistive ex c̄ (L) hip/knee		
Ambulation / Transfers	Amb 25'x2 w/w SBA - limited 2° fatigue, feeling like (L) knee is giving out.		
Function	Still w/c bound, amb limited to 5-8' for transfers/toileting 2° instability c̄ ↑ distance		
Therapist Comments	would like to extend PT to 3w2, 2w3 effective wk of 6/19/10 for strengthening, cont educ/upgrade HEP, work on fx'l mobility + gait		
Plan (*)	☐ Complete remaining (_____) visits per plan ☐ Extend current orders by (____)visits for (____) weeks ☐ D/C Patient at this time to (self care) (outpatient PT) (Circle one) ☒ Other Extend PT 3w2, 2w3 effective 6/19/10		
Therapist Name (Print)	Anne Coffman		
Therapist Signature	ACoffman PTMSGCS	Date	6/21/10
Phone Number	414-550-7677	Fax Number	6222

PHYSICIAN ORDERS/ COMMENTS:

☒ *Approve plan as above*

☐ *Change plan as follows* ________________

Physician Signature: [signature] *Date:* 6/23/10

White – Clinical Record
Yellow -- Clinician

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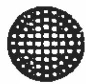
GCL3018 created 2/08

 GENTIVA®

PATIENT NAME Brannon, Maryanne CLIENT # 18847

PHYSICIAN NAME Dr. Sean Wilson PHYSICIAN PHONE # 1-262-780-4400

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP 19474 W. North Avenue Brookfield WI 53040

COMMUNICATION WITH PHYSICIAN MSW spoke with Ann, adm. assistant, 1 additional visit approved by Dr. Wilson

Clinician Signature: [signature], MSW Date: 7/8/2010

PHYSICIAN'S INTERIM ORDER

Dear Dr. Wilson,

This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 7/8/2010 **Date Interim Order to be Discontinued [if known]:**

Change Primary DX to: N/A

Change Pertinent DX to: N/A

Orders: One additional social worker visit to provide transportation resources + to assist with Power of Attorney for Health Care

Frequency 1W1 week of 7/19/10

625.9

Clinician Signature ▶ [signature] Date 7/8/2010

Reviewed by: (Signature/Title) ▶ Date

Physician Signature ▶ Date

© Gentiva Health Services 20
GCL1321 (11/

PATIENT NAME Brannon, Maryanne CLIENT # 18847

PHYSICIAN NAME Dr. Sean Wilson PHYSICIAN PHONE # 1-262-780-4600

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP 19474 W. North Avenue Brookfield WI 53040

COMMUNICATION WITH PHYSICIAN MSW spoke with Ann, adm. assistant, 1 additional visit approved by Dr. Wilson

Clinician Signature: [signature], MSW Date: 7/8/2010

PHYSICIAN'S INTERIM ORDER

Dear Dr. Wilson

This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: ______ Date Interim Order to be Discontinued (if known): ______

Change Primary DX to: N/A

Change Pertinent DX to: N/A

Orders: One additional social worker visit to provide transportation resources + money for Health Care

Frequency week of 7/19/10

Add to order

6259

Clinician Signature [signature] Date 7/12/10

Reviewed by: (Signature/Title) ______ Date ______

Physician Signature ______ Date ______

White – Clinical Record
Yellow – Physician

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

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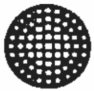 GENTIVA
orthopedics

PATIENT PROGRESS REPORT

(Circle one) PT OT

Physician	Dr Sean Wilson
Diagnosis/ Procedure	(R) ankle ORIF
Patient Name	Brannon, Mary Ann
DOB	
Patient #	18847
Patient Comments	
Pain (0-10) Scale	5/10 (L) ankle c̄ wt bearing - (R) ankle no c/o pain
Observation	pt really struggling with cast - hoping it will be removed. Difficulty being alone at home + so limited c̄ mobility
ROM / Strength	working on (L) ankle strength - didn't do last wk 2° ↑ pain (pt was overdoing activity at home) pt tolerating min/mod manual resistance this wk
Ambulation / Transfers	Have decreased amb in last 7-10 days 2° pt not feeling well - Dx'ed over wknd c̄ ear infection + on new meds for this. Was ambulating 45-50' x2 w/w c̄ NWB (R) - hope to resume p̄ MD appt
Function	mostly w/c level - self transfers to recliner/w/c/toilet needs @ c̄ showers - Difficulty c̄ medication management
Therapist Comments	Requesting RN to see pt for O+A, med mngmt - if needed, wound care if cast removed + any wounds
Plan	☐ Complete remaining (_____) visits per plan ☒ Extend current orders by (2) visits for (1) weeks 1 visit x 1 wk effective 7/24/1[0] ☐ D/C Patient at this time to (self care) (outpatient PT) (Circle one) ☒ Other plan to see pt through 8/3/10 then recertify + cont. rehab
Therapist Name (Print)	Anne Coffman
Therapist Signature	ACoffman PT MS GCS
Date	7/12/10
Phone Number	414-550-7677
Fax Number	

PHYSICIAN ORDERS/ COMMENTS:

~~6280~~ 6336

☒ Approve plan as above
☐ Change plan as follows ↑ WB (L) LE + B/L 15% WB c̄ (R) to even out B/L LE pressure. work c̄ proprioception/ strength training

Physician Signature: [signature] Date: 7/14/10

White – Clinical Record
Yellow -- Clinician

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GCL3018 created 2/08

Patient Name (last, first): Brannan, Maryann

Patient Number: 18847

14 HME:

- ☐Bedside Commode
- ☐Cane
- ☐Elevated Toilet Seat
- ☐Grab Bars
- ☐Hospital Bed
- ☐Tub/Shower Bench
- ☐Wheelchair
- ☐Walker
- ☐Other ______

SUPPLIES:

- ☐ABDs
- ☐Ace Wrap
- ☐Alcohol Pads
- ☐Chux/Underpads
- ☐Diabetic Supplies
- ☐Drainage Bag
- ☐Hydrocolloid
- ☐Exam Gloves
- ☐Foley Catheter
- ☐Gauze Pads
- ☐Irrigation Set
- ☐Irrigation Solution, Type: ______
- ☐Insertion Kit
- ☐Rolled Gauze
- ☐Leg Bag
- ☐Needles
- ☐NG Tube
- ☐Syringe
- ☐Tape
- ☐Other (Specify): ______

Supply Specifics: ______

Safety measures/additional equipment recommended to protect patient from injury ______

Specific safety issues discussed: ______

Patient/Family able to use all equipment/supplies safely? ☒Yes ☐No

21 ORDERS FOR DISCIPLINE & TREATMENTS:

☐SN Visit Frequency ______

☐SN may make ______ PRN visits for ______

☐HHA Visit Frequency ______ to assist with personal care/ADLs/light housekeeping as needed

☐PT Services (specify): ______

☐OT Services (specify): ______

☐ ______ (discipline) ______ PRN, visit for ______

☐ST Services (specify): ______

☐Dietician evaluation (specify): ______

☐May take orders from ______

☐Other (specify): ______

22 GOALS - See Protocols (specify): ______

Rehabilitation potential for goal achievements: ☐Poor ☐Fair ☐Good

DISCHARGE PLANS:

☐Patient to be discharged when skilled care is no longer needed
☐Patient to be discharged to the care of:
☐Self ☐Caregiver ☐Other (specify): ______

Anticipated Discharge Date: ______

☐Discharged plan initiated
☐No plans to discharge (Patient requires ongoing care)
☐Other (specify): ______

Conclusions/Impressions from Assessment: Pt alert and oriented but forgetful. Pt lives c̄ husband who helps pt out at times but not always available. SN for assessment/care of Ⓡ ankle wounds. Pt admits missing or possible double dosing c̄ meds. Pt willing to try weekly pill box to help prevent errors but is not ready to try setting up herself but will observe several times prior to participating and will adjust to taking out of pill box. Pt has nebulizer tx but not doing. Pt nebulizer several years old and pt hasn't used and doesn't have right equipment

Skilled Services provided this visit: Assess med compliance and pt knowledge of meds. Assess Ⓡ ankle wounds. Cleanse c̄ NS. Apply sterile gauze. Cover c̄ Kerlix Secure c̄ tape. Assess pt knowledge of nebulizer treatment and willness. Pt wants to learn. PCP contacted for new script to be sent to Neb Doctors for new equipment so that pt can be taught

☐Patient/Caregiver was involved in care planning ______ ☐See Documentation Addendum

☐Physician notified of abnormal assessments

Physician contacted & approved orders, discipline and frequency ☒Yes ☐No

Ordering Physician Name: Wilson, Sean

Verbal order date: 7/19/10 Specify: [illegible]

Nurse's Signature/Title: [signature] RN 7/15/10

Approved by/Date/Initials: ______

PATIENT NAME Maryann Brannon PATIENT DOB 9/29/51 OFFICE 0247 PATIENT # 18847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 328-8686

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP

COMMUNICATION WITH PHYSICIAN per conversation c Lynn.

Clinician Signature: Patty [illegible] R Date: 7/19/10

PHYSICIAN'S INTERIM ORDER

Dear

This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 7/19/10 **Date Interim Order to be Discontinued (if known):**

Change Primary DX to:

Change Pertinent DX to: SN for assessment and instruction of

Orders: medication in weekly pill box. Assessment/Perform wound care to Ⓡ inner/outer ankle. Cleanse c NS Apply dry sterile dressing. Secure c Kerlix and tape. daily x 4 visits. Then start c application of Silvasorb to wound and continue c dry sterile dressings every other day. 3PRN visits for dressing malfunction or additional instructions. On use of nebulizer treatment once delivery of neb equipment. May take orders from PCP Shahida Munim 543-1441 fax 543-1521 Effective week of 7/15/10 2w1, 5w1, 4w1, 2w1 SN to assess cardio/Resp and notify PCP if O_2 <90% prn

6284

Clinician Signature ▶ Patty [illegible] RN Date 7/19/10

Reviewed by: (Signature/Title) ▶ Date

Physician Signature ▶ [signature] Date 9/15/10

White – Clinical Record
Yellow – Physician
Pink – Clinical Record

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

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GCL1321 (04/08)

OFFICE 0247

PATIENT NAME Mary Ann Brannon PATIENT DOB 9/29/51 PATIENT # 18847

PHYSICIAN NAME Dan Wilson PHYSICIAN PHONE # 262-780-4400

Aspen Orthopaedic & Rehabilitation Specialists, S.C.

NAME Mary Ann Brannon

ADDRESS [illegible] DATE 7/[illegible]/10

Apply Betadine Soln. gauze paper tape

Date:

...ven at that time. ...date indicated below.

...patient for services.

Date Interim Order Obtained: 7/22/10 Date Interim Order to be Discontinued (if known):

Change Primary DX to:

Change Pertinent DX to: Effective week of 7/22/10 1w1, 3w1, 2w1

Orders: SN to perform/assess Ⓛ lat ankle wound every other day. Cleanse c̄ NS Apply betadine Cover c̄ gauze. Secure c̄ paper tape. 3PRN SN for dressing malfunction or additional education on use of [illegible]

6813

Clinician Signature ▶ Patty [illegible] Date 7/22/10

Reviewed by: (Signature/Title) ▶ Date

Physician Signature ▶ Date 9/20/10

White – Clinical Record
Yellow – Physician
Pink – Clinical Record

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

© Gentiva Health Services 2[illegible]
GCL1331 (0[illegible]

GENTIVA®

PATIENT NAME MaryAnn Brannon PATIENT DOB 9/29/51 OFFICE 0247

PATIENT # 18847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 262-780-4400

Aspen Orthopaedic & Rehabilitation Specialists, S.C.

- ☐ LEE M. TYNE, M.D.
- ☐ PATRICK W. CUMMINGS, M.D.
- ☐ JAMES P. WOOD, M.D.
- ☐ JEFFREY E. LARSON, M.D.
- ☐ SUSAN M. LARSON, M.D.
- ☐ AMY K. PRANTA, M.D.
- ☐ RYAN J. KEHOE, M.D.
- ☑ SEAN E. WILSON, D.P.M.
- ☐ ROBBY A. AMIOT, D.P.M.

19475 W. NORTH AVENUE, SUITE 201, BROOKFIELD, WISCONSIN 53045, (262) 780-4400 FAX: (262) 780-4425

2424 S. 90TH STREET, SUITE 500, WEST ALLIS, WISCONSIN 53227, (414) 328-8600 FAX: (414) 328-8686

721 AMERICAN AVENUE, SUITE 205, WAUKESHA, WISCONSIN 53188, (262) 928-8600 FAX: (262) 928-8606

NAME Mary Ann Brannon

ADDRESS 9/29/51 DATE 7/22/10

℞ Eschar lat wound Ⓡ ankle s/p ORIF

Apply Betadine soln. c gauze / paper tape q o d

Label

Refills: 0 1 2 3

[signature]

Date:

...ven at that time.

...date indicated below.

... patient for services.

Date Interim Order Obtained: 7/22/10 Date Interim Order to be Discontinued [If known]:

Change Primary DX to:

Change Pertinent DX to: Effective week of 7/22/10 1w1, 3w1, 2w1

Orders: SN to perform/assess Ⓡ lat ankle wound every other day. Cleanse c NS. Apply betadine. Cover c gauze. Secure c paper tape. 3PRN SN for dressing malfunction or additional education on use of nebulizer.

6813

Clinician Signature ▶ Patty [signature] Date 7/22/10

Reviewed by: (Signature/Title) ▶ Date

Physician Signature ▶ Date

White – Clinical Record
Yellow – Physician

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

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OFFICE 0247

PATIENT NAME Maryann Brannon PATIENT DOB 9/29/51 PATIENT # 18847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 328-8626

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP

COMMUNICATION WITH PHYSICIAN per conversation c̄ Lynn

Clinician Signature: Patty [illegible] RN Date: 8/12/10

PHYSICIAN'S INTERIM ORDER

Dear
This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time.
The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below.
Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 8/12/10 Date Interim Order to be Discontinued (if known):

Change Primary DX to:

Change Pertinent DX to:

Orders: 8-12-10 - 1 PRN visit for addition wound assess by SN due to ↑ pain. Wound care frequency changed every other day to (R) outer ankle. Cleanse c̄ NS. Apply betadine gel. Cover c̄ gauze. Secure c̄ Kerlix and tape. Kerlix secure to avoid possible adhesive allergic reaction. Continue to assess for S/S of infection. Frequency effective 8-14-10 4w1, 3w1, 4w1, 3w1, 4w1, 3w1, 4w1, 3w1 + 2 PRN for additional wound care assessment or dressing change due to malfunction

6851

Clinician Signature Patty [illegible] RN Date 8/12/10

Reviewed by: (Signature/Title) Date

Physician Signature [signature] Date 8/17/10

OFFICE 0247

PATIENT NAME Maryann Brannon PATIENT DOB 9/29/51 PATIENT # 18847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 328-8626

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP

COMMUNICATION WITH PHYSICIAN per conversation c Lynn

Clinician Signature: Patty [signature] RN Date: 8/12/10

PHYSICIAN'S INTERIM ORDER

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A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 8/12/10 Date Interim Order to be Discontinued (if known):

Change Primary DX to:

Change Pertinent DX to:

Orders: 8-12-10-1 PRN visit for addition wound assess by SN due to ↑ pain. Wound care frequency change every other day to R outer ankle. Cleanse c NS Apply betadine gel. Cover c gauze. Secure c Kerlix and tape. Kerlix secure to avoid possible adhesive allergic reaction. Continue to assess for S/S of infection. Frequency effective 8-14-10 4w1, 3w1, 4w1, 3w1, 4w1, 3w1, 4w1, 3w1 [illegible] 2 PRN for additional wound care assessment or dressing change due to malfunction

6351

Clinician Signature: Patty [signature] RN Date 8/12/10

Reviewed by: (Signature/Title) Date

Physician Signature [signature] Date 8/17/10

Aspen Orthopaedic & Rehabilitation Specialists, S.C.

☐ LEE M. TYNE, M.D.
☐ PATRICK W. CUMMINGS, M.D.
☐ JAMES P. WOOD, M.D.
19475 W. NORTH AVENUE, SUITE 201
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WEST ALLIS, WISCONSIN 53227
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☐ ~~AMY K.~~ FRANTA, M.D.
☑ SEAN E. WILSON, D.P.M.
☐ ROBBY A. AMIOT, D.P.M.
721 AMERICAN AVENUE, SUITE 205
WAUKESHA, WISCONSIN 53188
(262) 928-8600 FAX: (262) 928-8606

NAME Mary Ann Brannon DATE 8/17/10

ADDRESS

℞ Dx: lat ankle dehiscence
ORIF (R) ankle fx

Avg. daily: clean c̄ peroxide saline/alcohol, then betadine left around wound & ↓ dressing gauze, paper tape

Label
Refills: 0 1 2 3

[signature]

file

PATIENT NAME Maryann Brannon PATIENT DOB ______ OFFICE 0247 PATIENT # 1847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 328-8600

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP

COMMUNICATION WITH PHYSICIAN per conversation c lynn.

Clinician Signature: ▶

Date:

PHYSICIAN'S INTERIM ORDER

Dear ______
This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 8-17-10 **Date Interim Order to be Discontinued [if known]:**

Change Primary DX to:

Change Pertinent DX to: Effective 8-18-10. SN to perform daily

Orders: wound care to (L) outer ankle: Cleanse c peroxide, saline, alcohol then apply betadine felt / foam pad around wound to decrease pressure. Cover c gauze. Secure c tape. Expected end date to daily wound care 11-17-10

6417
~~5135~~

Clinician Signature ▶ Patty [illegible] RN Date 8-17-10

Reviewed by: (Signature/Title) ▶ Date

Physician Signature ▶ [signature] Date 9/20/10

White – Clinical Record
Yellow – Physician
Pink – Clinical Record

PHYSICIAN'S COMMUNICATION & INTERIM ORDER

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OFFICE 0217

PATIENT NAME Maryann Brannon PATIENT DOB ______ PATIENT # 18847

PHYSICIAN NAME Sean Wilson PHYSICIAN PHONE # 328-9600

PHYSICIAN'S ADDRESS, STREET, CITY, ZIP ______

COMMUNICATION WITH PHYSICIAN per conversation c lynn

Clinician Signature: Date:

PHYSICIAN'S INTERIM ORDER

Dear ______

This is to confirm our conversation on date indicated below and authorization of verbal orders listed below given at that time. The orders shown below are being forwarded for your signature to authorize your verbal orders given on the date indicated below. Please sign and return this form within 48 hours of receipt for our patient's clinical record.

A pre-stamped, pre-addressed envelope is enclosed for your convenience. Thank you for the referral of your patient for services.

Gentiva Health Services

Date Interim Order Obtained: 8-17-10 Date Interim Order to be Discontinued [if known]: ______

Change Primary DX to:

Change Pertinent DX to: Effective 8-18-10. SN to perform daily

Orders: wound care to (B) outer ankle: cleanse c peroxide, saline, alcohol then apply betadine felt/foam pad around wound to decrease pressure. Cover c gauze. Secure c tape. Expected end date to daily wound care 11-17-10

2156

Clinician Signature Patty Preston RN Date 8-18-10

Reviewed by: (Signature/Title) Date

Physician Signature [signature] Date 9/9/10

PHYSICIAN COMMUNICATION & INTERIM ORDER

Patient Name (Last, First) Brannon, Mary Ann

Client No. 18847

☐ Progress Summary ☐ Transfer Summary ☒ D/C Summary ☐ Case Conference

Covering Period - From 8/4/10 To 10/2/10

SOC DATE: 6/5/10 DC DATE: 9/16/10

Service Provided and Classification (Check all services provided. If discharged, fill in # of visits/shifts, if required by State.)

☐ RN ____ ☒ PT 47 ☐ SLP ____ ☐ HHA ____ ☐ RT ____ ☐ Homemaker ____ ☐ Companion ____

☐ LP (V)N ____ ☐ OT ____ ☐ MSW ____ ☐ PCA ____ ☐ NT ____ ☐ Housekeeper ____ ☐ Other ____

Primary Diagnosis: (R) ankle fx c ORIF

Other Pertinent Diagnosis:

☐ Case Conference attended by: (Names/Titles)

☐ **Clinical Record Reviewed** Summary of Patient's Conditions, Care Provided, and Status of Problems throughout course of care:

Pt made good progress c PT - initially NWB, required training in transfers, bed mob, gait. Once partial WB in boot, progressed gait ↑ (I) c mobility, began specific ankle ROM/strength. Once WBAT, progressed to cane, outdoors, stairs - now (I) c cane even/uneven surfaces, outdoors up to 4 blocks, stairs. Ankle ROM ↑ to 8° DF AROM, 15° PROM, 21° PF AROM, 25° PROM, 10° inversion, 5° eversion MMT DF 4+, PF 4, inversion 4, eversion 4-/5. Pt was taught general HEP as well as specific ankle ex. Pt had onset (L) shd/wrist pain ~2 wks ago — due to acute nature of injury, did not actively tx shd but educ pt in rest, ice, ↓ use - Pt starts outpt PT next wk for shd/wrist.

MD is aware of progress c d/c

Goals Met? ☒ Yes ☐ No, If no, explain: Pt met or exceeded all goals

SENT TO PHYSICIAN
DATE/INITIAL 10-2-10 RMT

COMPLETE FOR DISCHARGE/TRANSFER

☐ 01 Discharge to Home or Self Care
☐ 02 Sent to Short-Term Hospital
☐ 03 Sent to Skilled Nursing Facility
☐ 04 Sent to Intermediate Care Facility
☐ 05 Sent to a Different Type of Institution
☐ 06 Sent Home with a Different Provider
☐ 07 Left Against Medical Advice
☐ 09 Family/Friends Assume Responsibility
☐ 10 Sent to Outpatient Rehab
☐ 11 Transfer by Doctor Request
☐ 12 Discharged for Lack of Progress
☐ 13 Discharged for Lack of Funds
☐ 14 Discharged for Other Reason
☐ 15 Patient Moved Out of Area
☒ 16 Patient Has Achieved Maximum Rehab Possible
☐ 17 Patient/Family Non-Compliant
☐ 18 Patient No Longer Homebound
☐ 19 Patient Refuses Further Services
☐ 20 Expired
☐ 40 Expired at Home
☐ 41 Expired in Hospital, SNF, ICF
☐ 42 Expired, Place Unknown
☐ 43 Discharged to Federal Hospital
☐ 50 Discharged to CHHA
☐ 51 Discharged to Long-Term Care Facility
☐ 52 Discharged to Long-Term Care Home Care Agency
☐ 53 Discharged to Department of Social Services
☐ 54 Discharged to Community Agency

Date of last visit/shift 9/16/10 (Discharge/Transfer date): 9/16/10 Last discipline out ☒ Yes ☐ No Specify: ____

Advance Directive Exists ☐ Yes ☐ No Specify: ____

Discharge/Transfer to: remain (I) at home Referrals made to other community services? ☐ Yes ☐ No

Comments/Specify: ____

Summary sent to: ☐ Case Manager ☐ Physician ☐ Discharge Planner ☐ Facility ☐ Other ____

Preparer's Signature/Title [signature] Roman DPMS(PT) Date 9/16/10

Signature Required? ☐ Yes ☐ No
Physician's Signature: Date

EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert. | Location Name: Milo | Location No.: 0247

Employee No.	Employee Name (last, first)	Patient No.	Patient Name (last, first)
738	Austin, Patty	18847	Brannon, Maryann

Pay/Bill Code	Shift	Date of Service m/d/y	Service Time	Travel Time	Travel Duration	Mileage
010	D	9/6/10	Start 822 ☒ am ☐ pm / Stop 847 ☐ am ☒ pm	Start 754 ☒ am ☐ pm / Stop 822 ☒ am ☐ pm	28	Mileage / Bill Mileage ☐ Yes ☐ No

Patient Time		Non-Billable Visit Duration (NBD)		Chart Time		Total Time	
Hrs	Min	Hrs	Min	Hrs	Min	Hrs	Min

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ Overtime
Override Bill Rates ☐ Yes ☐ No
Override Pay Rates ☐ Yes ☐ No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Patient Signature X: Mary A Brannon
Employee Signature: Patty Austin
Validated By Initials/Date:

Vital Signs

T: 97.6 P: 76 R: 18

Weight: ____ ☐ Gain ☐ Loss Since last visit: ____

BP	Lying	Sitting	Standing
Right:		110/64	
Left:			

☐ Pt/cg self monitoring: ☐ T ☐ P ☐ BP ☐ SpO_2

Comments:

Supervision

☐ N/A ☐ Aide ☐ LPN/LVN

Present on this visit: ☐ Yes ☐ No
Name if present:
Following Care Plan: ☐ Yes ☐ No Compatible: ☐ Yes ☐ No
Report changes in patient status to office: ☐ Yes ☐ No
Changes to care plan: ☐ Yes ☐ No
Additional Instructions provided during visit: ☐ Yes ☐ No
Comments:

Pain Assessment

Frequency of Pain interfering with patient's activity or movement:

☐ Patient has no pain ☐ Pain does not interfere with activity or movement
☐ Less often than daily ☒ Daily, but not constantly ☐ All of the time
Pain Rating: 0 /10 Scale Used: ☐ Numeric ☐ FLACC ☐ Faces
Location(s): ____ Pain Precipitated by: ____
Pain Duration: ____ Pain Relieved by: ____
Is current pain management effective?: ☐ Yes ☐ No *(explain below)*

Respiratory

☐ N/A Assessed/Observed the following:

Breath Sounds: ☒ Clear: (R / L) ☐ Wheezes: R / L
☐ Crackles: R / L fine or coarse
☐ Dyspnea at rest and/or supine ☐ Dyspnea with ADLS
☐ Dyspnea on minimal exertion ____ ft/ ____ min
Cough: ☐ Dry ☐ Productive ☐ Hemoptysis
Sputum: color: ____ consistency: ____
Incentive Spirometry: ____ cc
☐ Oxygen ____ L/min ☐ Nasal cannula ☐ Mask
☐ Other ____ ☐ Continuous ☐ PRN
☐ Tracheostomy:
☐ Ventilator:
☐ SpO_2: 98% ☒ No Problems identified
Comments:

Labs

☒ N/A ☐ VP # Attempts:

Draw/Site:
Test Performed: ____ Lab Delivered to: ____
Applicable Drug Last Dose/Time:
☐ PT/INR Results:
Results/Comments:

Neurological

☐ N/A Assessed/Observed the following:

☒ Alert ☒ Oriented ☒ Forgetful ☐ Confused ☐ Disoriented
☐ Lethargic ☐ Depressed Weakness: ☐ Right side ☐ Left side
☐ Dizziness ☐ Tremors Paralysis: ☐ Right side ☐ Left side
☐ Headaches ☐ Difficulty Swallowing ☐ Recent Seizure Activity
☐ No Problems identified
Comments:

Endocrine

☒ N/A Assessed/Observed the following:

☐ Performs own glucose monitoring without problems
Patient reported Blood Sugar range:
☐ Burning/numbness/tingling/loss of sensation of feet
☐ Hypoglycemia ☐ Hyperglycemia
Blood Sugar: ____ mg/dl ☐ Fasting ☐ Random
☐ No Problems identified
Comments:

Cardiovascular

☐ N/A Assessed/Observed the following:

Heart Sounds: ☒ Regular ☐ Muffled/Distant ☐ Gallop
☐ Irregular ☐ Murmur ☐ Other: ____
☐ Palpitations ☐ Bradycardia ☐ Tachycardia ☐ Angina
Pedal Pulses Palpable: ☐ Right Side ☐ Left Side
☐ Edema Location: ____ ☐ Abnormal Capillary Refill(>3 seconds) ☐ Pacemaker ☐ AICD
Right: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Left: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
☒ No Problems identified
Comments: Ankle swollen minimal

Nutrition

☒ N/A Assessed/Observed the following:

Diet type: ☐ Regular ☐ Diabetic
☐ Low Fat/NAS/Low Cholesterol ☐ Renal
☐ Other:
☐ Fluid Restriction: ____ /24 hrs ☐ Poor Appetite
☐ Poor Dietary Compliance ☐ Chewing Problems
☐ Lack of Food Available
☐ NG ☐ G-tube/PEG ☐ Jejunostomy
Enteral Feedings: ☐ Continuous ☐ Pump ☐ Gravity
☐ Bolus Type: ____ Rate: ____
☐ No Problems Identified
Comments:

Genitourinary

☐ N/A Assessed/Observed the following:

☒ Voiding without problems
Incontinence: *(type)* ☐ Functional ☐ Stress ☐ Urge ☐ Overflow
☐ Retention ☐ Urine odor ☐ Pain ☐ Burning ☐ Hesitancy
☐ Hematuria ☐ Anuria ☐ Dialysis ☐ Renal Insufficiency/Failure
☐ Nephrostomy: R/L/Bilateral ☐ Self Intermittent Catheterization
Catheter Type: ☐ Urethral ☐ SP ☐ External ☐ Other ____ ☐ BSD Bag ☐ Leg Bag
Catheter Change This Visit: ____ size catheter ____ size balloon filled with ____ sterile H_2O
Comments:

Medications

Assessed/Observed the following:

Compliant with regimen: ☒ Yes ☐ No
Available in home as ordered: ☒ Yes ☐ No
New/Changes since last visit: ☒ No ☐ Yes (list below)

☐ Adverse event/reaction/interaction/significant side effects:

Communication: ☐ Physician ☐ Pharmacy
Meds managed by: patient
Comments:

Gastrointestinal

☒ N/A Assessed/Observed the following:

Date of last BM: 9/5/10 ☐ Oral Lesions, Sores
☐ Abdomen Soft ☐ Bowel Sounds Present ☐ Bowel Sounds Sluggish
☐ Constipation ☐ Bowel Sounds Absent ☐ Incontinence
☐ Bloody/Tarry Stools ☐ Diarrhea ☐ Increased Flatulence
☐ Ileostomy ☐ Abdomen Distended ☐ Self Manages Ostomy
☐ Gum Problems ☐ Colostomy ☐ Other: ____
☒ No Problems identified
Comments:

Date: 9-6-10 Patient Name: Brannon Patient No. 1884?

Integumentary

☐ No Problems identified/Skin Intact ☐ Diabetic Foot/Skin Assessment Completed ☒ No S/S of infection

☐ ________ (site) Surgical Wound Approximated/intact: ☐ Staples ☐ Sutures ☐ Steri-strips ☐ Skin/Surgical Adhesive

Location	Wound Type	Dimensions	Exudated, Amount, Type, Color	Wound Tissue Type (circle % for each type present)	Surrounding Skin, Wound Margins
® outer ankle	surgi	L: ____ cm W: ____ cm D: ____ cm Tunneling/Undermining @ ____-____ cm	☒ None ☐ Scant ☐ Small ☐ Medium ☐ Large ☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor ☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: Scab – 100 %	☒ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ____
		L: ____ cm W: ____ cm D: ____ cm Tunneling/Undermining @ ____-____ cm	☐ None ☐ Scant ☐ Small ☐ Medium ☐ Large ☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor ☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ____ – ____ %	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ____

Location: ® outer ankle	Location:
Cleansed with: peroxide	Cleansed with:
Dressed with: alcohol wipe	Dressed with:
Packed with:	Packed with:
Covered with:	Covered with:
Secured with:	Secured with:

Pressure Reduction Equipment In Use: ☐ Wheelchair Cushion ☐ Replacement Mattress ☐ Mattress Overlay ☐ Specialty Bed: ____

Comments: ____

Musculoskeletal ☐ N/A Assessed/Observed the following: ☐ Assistive Device(s) in Use: (list) cane

☒ Fall Risk Recent Fall Since Last Visit: ☐ Yes ☒ No ☐ If yes, Clinical Manager/Physician Notified ☒ No problems identified

Comments: ____

Homebound ☒ N/A ☐ Patient is Homebound due to (state in specific measurable and functional terms): ____

Comments: ____

Skilled Instruction - Key: 1 = verbalizes understanding; 2 = return demonstration; 3 = needs further instruction; 4 = goal met

Patient/Caregiver instruction:	Specify:	1	2	3	4	Patient/Caregiver Instruction:	Specify:	1	2	3	4
☐ 1. disease process						☐ 10. ostomy care/foley care					
☐ 2. S/S complications						☐ 11. bowel/bladder training					
☐ 3. medications						☐ 12. infection control					
☐ 4. IV/TPN						☐ 13. emergency plan					
☐ 5. inhalation/O2 therapy/safety						☐ 14. falls precaution					
☐ 6. pain management						☐ 15. equipment					
☐ 7. wound/decubitus care						☐ 16. anticoagulant precautions					
☐ 8. nutrition/dehydration						☐ 17. hypoglycemic precautions					
☐ 9. diabetic care						☐ 18. Other:					

Details of Skilled instruction: ____

Additional Skilled Care Provided ☐ See (indicate Note/Addendum): SN for wound assessment. Pt

Comments: reports wiping area clean with alcohol wipe or betadine. Pt reports yesterday some yellow drainage. Instructed pt that could have been betadine. Wound scab looks clean and no s/s of infection. Pt also report ?wrist discomfort at times. Instructed pt that d/t ↑ use of cane could cause discomfort and to stretch wrist and notify PT for any additional exercises

Patient response to care provided: pleased

Supplies Used ____

COORDINATION PLAN

Patient's Progress Towards Goal/Goals Resolved this Visit? (specify) progressing

Contacted/conference with: Physician SN PT OT SLP MSS HHA Other (circle) Name: ____ Date/Time: ____

Regarding: ____

Response: ____ See Interim Order: ☐ Yes ☐ No

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan ____ MD Appt. Date ____

Plan for Next Visit: skin assessment

Discharge Planning: until SN no longer needed

EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert. | Location Name: Milw | Location No. 0247

Employee No.	Employee Name (last, first)	Patient No.	Patient Name (last, first)
138	Austin Patty	18847	Brannon, Maryann

Pay/Bill Code	Shift	Date of Service m/d/y	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
010	D	9/8/10	1:26 ☒pm	2 ☒pm	1:04 ☒pm	1:20 pm		Mileage Bill Mileage ☐ Yes ☐ No

Patient Time Hrs	Min	Non-Billable Visit Duration (NBD) Hrs	Min	Chart Time Hrs	Min	Total Time Hrs	Min
					5		

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ Overtime | Override Bill Rates ☐ Yes ☐ No | Override Pay Rates ☐ Yes ☐ No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Patient Signature X [signature] | Employee Signature [signature: Patty Austin] | Validated By Initials/Date: [initials] 9-14-10

Vital Signs

T: 98.1 P: 100 R: 18

Weight: ☐ Gain ☐ Loss Since last visit:

BP	Lying	Sitting	Standing
Right:		118/78	
Left:			

☐ Pt/cg self monitoring: ☐ T ☐ P ☐ BP ☐ SpO_2

Comments:

Pain Assessment

Frequency of Pain interfering with patient's activity or movement:

☐ Patient has no pain ☐ Pain does not interfere with activity or movement
☐ Less often than daily ☒ Daily, but not constantly ☐ All of the time

Pain Rating: 7 /10 Scale Used: ☐ Numeric ☐ FLACC ☐ Faces

Location(s): Bil/am wrist Pain Precipitated by: using

Pain Duration: Constant Pain Relieved by: Rest

Is current pain management effective?: ☒ Yes ☐ No *(explain below)*

Labs

☒ N/A ☐ VP # Attempts:

Draw/Site:

Test Performed: Lab Delivered to:

Applicable Drug Last Dose/Time:

☐ PT/INR Results:

Results/Comments:

Neurological

☐ N/A Assessed/Observed the following:

☒ Alert ☒ Oriented ☒ Forgetful ☐ Confused ☐ Disoriented
☐ Lethargic ☐ Depressed Weakness: ☐ Right side ☐ Left side
☐ Dizziness ☐ Tremors Paralysis: ☐ Right side ☐ Left side
☐ Headaches ☐ Difficulty Swallowing ☐ Recent Seizure Activity
☐ No Problems Identified

Comments: anxious off/on

Cardiovascular

☐ N/A Assessed/Observed the following:

Heart Sounds: ☒ Regular ☐ Muffled/Distant ☐ Gallop
☐ Irregular ☐ Murmur ☐ Other:
☐ Palpitations ☐ Bradycardia ☐ Tachycardia ☐ Angina
Pedal Pulses Palpable: ☐ Right Side ☐ Left Side
☐ Edema Location: ☐ Abnormal Capillary Refill(>3 seconds) ☐ Pacemaker ☐ AICD
Right: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Left: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
☒ No Problems identified

Comments:

Genitourinary

☐ N/A Assessed/Observed the following:

☒ Voiding without problems
Incontinence: *(type)* ☒ Functional ☐ Stress ☐ Urge ☐ Overflow
☐ Retention ☐ Urine odor ☐ Pain ☐ Burning ☐ Hesitancy
☐ Hematuria ☐ Anuria ☐ Dialysis ☐ Renal Insufficiency/Failure
☐ Nephrostomy: R/L/Bilateral ☐ Self intermittent Catheterization
Catheter Type: ☐ Urethral ☐ SP ☐ External ☐ Other ☐ BSD Bag ☐ Leg Bag
Catheter Change This Visit: size catheter size balloon filled with sterile H_2O

Comments:

Gastrointestinal

☐ N/A Assessed/Observed the following:

Date of last BM: 9/8/10
☐ Oral Lesions, Sores
...en Soft ☐ Bowel Sounds Present ☐ Bowel Sounds Sluggish
...ation ☐ Bowel Sounds Absent ☐ Incontinence
...arry Stools ☐ Diarrhea ☐ Increased Flatulence
☐ Abdomen Distended ☐ Self Manages Ostomy
...ms ☐ Colostomy ☐ Other:
...Identified

Supervision

☐ N/A ☐ Aide ☐ LPN/LVN

Present on this visit: ☐ Yes ☐ No
Name if present:
Following Care Plan: ☐ Yes ☐ No Compatible: ☐ Yes ☐ No
Report changes in patient status to office: ☐ Yes ☐ No
Changes to care plan: ☐ Yes ☐ No
Additional instructions provided during visit: ☐ Yes ☐ No
Comments:

Respiratory

☐ N/A Assessed/Observed the following:

Breath Sounds: ☒ Clear: (R / L) ☐ Wheezes: R / L
☐ Crackles: R / L fine or coarse
☐ Dyspnea at rest and/or supine ☐ Dyspnea with ADLS
☐ Dyspnea on minimal exertion ___ ft/ ___ min
Cough: ☐ Dry ☐ Productive ☐ Hemoptysis
Sputum: color: consistency:
Incentive Spirometry: cc
☐ Oxygen L/min ☐ Nasal cannula ☐ Mask
☐ Other ☐ Continuous ☐ PRN
☐ Tracheostomy:
☐ Ventilator:
☐ SpO_2: 95% ☒ No Problems identified

Comments:

Endocrine

☒ N/A Assessed/Observed the following:

☐ Performs own glucose monitoring without problems
Patient reported Blood Sugar range:
☐ Burning/numbness/tingling/loss of sensation of feet
☐ Hypoglycemia ☐ Hyperglycemia
Blood Sugar: mg/dl ☐ Fasting ☐ Random
☐ No Problems identified

Comments:

Nutrition

☐ N/A Assessed/Observed the following:

Diet type: ☒ Regular ☐ Diabetic
☐ Low Fat/NAS/Low Cholesterol ☐ Renal
☐ Other:
☐ Fluid Restriction: /24 hrs ☐ Poor Appetite
☐ Poor Dietary Compliance ☐ Chewing Problems
☐ Lack of Food Available
☐ NG ☐ G-tube/PEG ☐ Jejunostomy
Enteral Feedings: ☐ Continuous ☐ Pump ☐ Gravity
☐ Bolus Type: Rate:
☒ No Problems identified

Comments:

Medications

Assessed/Observed the following:

Compliant with regimen: ☒ Yes ☐ No
Available in home as ordered: ☒ Yes ☐ No
New/Changes since last visit: ☐ No ☒ Yes (list below)

Naproxen 500mg - 1 tab PO BID

☐ Adverse event/reaction/interaction/significant side effects:

Communication: ☐ Physician ☐ Pharmacy
Meds managed by: patient
Comments:

Date: 9-8-10 Patient Name: Bannon Patient No. 1847

Integumentary ☐ No Problems Identified/Skin intact ☐ Diabetic Foot/Skin Assessment Completed ☒ No S/S of infection

☐ ______ (site) Surgical Wound Approximated/Intact: ☐ Staples ☐ Sutures ☐ Steri-strips ☐ Skin/Surgical Adhesive

Location	Wound Type	Dimensions	Exudated, Amount, Type, Color	Wound Tissue Type (circle % for each type present)	Surrounding Skin, Wound Margins
R outer ankle	Surgical	L: 0.2 cm W: 0.3 cm D: scab cm Tunneling/Undermining @ __-__ cm	☒ None ☐ Scant ☐ Small ☐ Medium ☐ Large ☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor ☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other:	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ___ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other:
		L: cm W: cm D: cm Tunneling/Undermining @ __-__ cm	☐ None ☐ Scant ☐ Small ☐ Medium ☐ Large ☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor ☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other:	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ___ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other:

Location: R outer ankle
Cleansed with: N.S
Dressed with: alcohol wipe
Packed with:
Covered with:
Secured with:

Location:
Cleansed with:
Dressed with:
Packed with:
Covered with:
Secured with:

Pressure Reduction Equipment in Use: ☐ Wheelchair Cushion ☐ Replacement Mattress ☐ Mattress Overlay ☐ Specialty Bed:
Comments:

Musculoskeletal ☐ N/A Assessed/Observed the following: ☐ Assistive Device(s) in Use: (list) cane
☒ Fall Risk Recent Fall Since Last Visit: ☐ Yes ☒ No ☐ If yes, Clinical Manager/Physician Notified ☒ No problems identified
Comments:

Homebound ☐ N/A ☐ Patient is Homebound due to (state in specific measurable and functional terms): Pt. fatigues c activity and pain/swelling ↑ to RLE which limits pt
Comments: mobility

Skilled Instruction - Key: 1 = verbalizes understanding; 2 = return demonstration; 3 = needs further instruction; 4 = goal met

Patient/Caregiver instruction:	Specify:	1	2	3	4	Patient/Caregiver instruction:	Specify:	1	2	3	4
☐ 1. disease process						☐ 10. ostomy care/foley care					
☐ 2. S/S complications						☐ 11. bowel/bladder training					
☐ 3. medications						☐ 12. infection control					
☐ 4. IV/TPN						☐ 13. emergency plan					
☐ 5. inhalation/O2 therapy/safety						☐ 14. falls precaution					
☐ 6. pain management						☐ 15. equipment					
☐ 7. wound/decubitus care						☐ 16. anticoagulant precautions					
☐ 8. nutrition/dehydration						☐ 17. hypoglycemic precautions					
☐ 9. diabetic care						☒ 18. Other: discharge.					

Details of Skilled instruction: Pt instructed that wound remains closed and will be dc next week and is referred to outpatient therapy by MD and will schedule for next week. Pt instructed last SN visit on 9/13/10

Additional Skilled Care Provided ☐ See (Indicate Note/Addendum): SN for S/S of R outer ankle
Comments: scab present No S/S of infection. Pt keeping clean and dry and wiping c betadine or alcohol wipe and leaving open to air. Pt using Tubigrip to RLE to help swelling and is aware to elevate leg off/on daily to help control. Pt understands to take new med 2x day and agrees c dc next week.

Patient response to care provided: pleased

Supplies Used

COORDINATION PLAN

Patient's Progress Towards Goal/Goals Resolved this Visit? (specify) progressing
Contacted/conference with: Physician SN PT OT SLP MSS HHA Other (circle) Name: Anne PT Date/Time:
Regarding: dc pt 9/13/10 and PT to dc on 9/16 after Dr Wilson appt
Response: agrees c plan of care
See interim Order: ☐ Yes ☐ No
☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan ______ MD Appt. Date
Plan for Next Visit: wound care
Discharge Planning: until SN no longer needed

EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert.

Location Name: Milwaukee | Location No. 0247 | Client No. 1847

Employee No.: 0753 | Employee Name (last, first): Woffman Anne | Patient Name (last, first): Brannon, Mary Ann

Pay/Bill Code	Shift	Date of Service (Month / Day / Year)	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
20		9 / 8 / 10	10:30 ☒am ☐pm	11:15 ☒am ☐pm	10:16 ☒am ☐pm	10:29 ☒am ☐pm	13	Mileage ____ Bill Mileage ☐Yes ☐No

Patient Time	Non-Billable Visit Duration (NBD)	Chart Time	Total Time
Hrs 40 Min	Hrs Min	Hrs 5 Min	Hrs 58 Min

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ OT

Override Bill Rates ☐Yes ☐No
Override Pay Rates ☐Yes ☐No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Supplies: Code ____ Quantity ____

Patient Signature: [signature] | Employee Signature: A Woffman PT MS GG | Approved by Initials/Date: [initials] 9/14/10

SKILLED OBSERVATION

VITAL SIGNS

T 97.9
P 64
R
Wt
BP 140/80 right / left
☐ Standing ☐ Lying ☒ Sitting

Applicable lab/fingerstick values

Last BM:

PAIN

Pain Addendum ☐ Yes ☒ No

Frequency of Pain interfering with patient's activity or movement:
☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often than daily
☒ 2 - Daily, but not constantly
☐ 3 - All of the time

PAIN PROFILE (L) shd

Intensity: 0 1 (Low) 2 3 4 5 6 (7) 8 9

Location(s) 7/10 (L) shd
Pain Precipitated by: 0/10 (B) ankles - still
Pain Duration: worried @ swelling
Pain Relieved by:
Current pain management & effectiveness:
☐ Pain Management Teaching to patient/family *(document below)*

Medication change since last visit? ☐ No ☒ Yes, Specify naprosen 500 mg - 1 tab po 2x/day eff. 9/7/10

Homebound Status (Describe) pt is cognition limits ability to follow precautions, limit mobility

SKILLED ASSESSMENT/INTERVENTION

Assessment relative to problems addressed this visit/new problems identified and services provided: pt saw 1° MD 9/7/10 - got Dx'ed c̄ (L) shd/unst pain/sprain - no known injury, no fall - pt s takes it no rest x 2 wks but hasn't said anything to PT during any Rx session pt up @ apt no shoes, no name - upset 2° family 1 ss ng, has 3 grandkids in the home today (L) shd - flex to 110°, ER very limited - pt also had flu shot so (L) shd very sore today will assess further next Rx - pt will start outpt after 9/17 - also MD 9/15 for ankle - will refer to outpt p̄ this ☐ See Addendum

Supplies Used: ☐ Billing for supplies used by Patient/Caregiver

SKILLED TEACHING / PATIENT RESPONSE

Instructions given to: Gait - amb indoors 2 blocks c̄ cane (R) -

Subject(s) taught: no antalgic gait, sl mod wbing on cane steps ↑↓ c̄ cane + step to pattern cues to sequence on way up - wearing

Patient/Caregiver is able to repeat/demonstrate the following: (L) unst brace from MD - no SOB no s/s fatigue though pt states she usually gets tired

Teaching plan for next visit: HEP - pt doing steps 3-4 x/wk stretch on outdoor incline ramp, standing therex - will do ankle ROM'ex

SUPERVISION

☐ Aide ☐ LP(V)N ☐ Other:
Present on this visit? ☐ Yes ☐
Following care plan? ☐ Yes ☐
Compatible? ☐ Yes ☐
Report changes in patient status to Office? ☐ Yes ☐
Patient satisfied with care? ☐ Yes ☐
Changes made to care plan? ☐ Yes ☐
Additional instruction given during visit? ☐ Yes ☐
Employee Name:

COORDINATION / PLAN

Patients Progress Towards Goal/Goals Resolved this Visit? (specify) pt doing well c̄ gait, ocean - will check ROM next visit (kids all @ house, pt very upset/distracted by them)

Conferenced With: SN PT OT SLP MSS HHA Other (circle) Name:

Regarding:

Physician Contacted Re: | Date/Time

Physician Response/Result | See Interim Order ☐ Yes ☐

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan: | MD Appt. Date

Plan for Next Visit: check (L) unst/shd, ankle ROM (B)

Discharge Planning: D/C next wk | ☐ Patient/Caregiver agreed with D/C

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Patient Name: Brannon, Mary Ann | Patient#: 18847

Answering yes to the following questions indicates continued skilled assessment, instruction, direct skilled care and/or **Observation and Assessment** by **Skilled Nursing** may be medically necessary.

Has the patient:

- ❑ Been in the Emergency Room/Hospital within the current cert period?
- ❑ Had significantly fluctuating vital signs/lab values within the past three weeks indicating that the status is not stabilized?
- ❑ Demonstrated any significant difficulties with following or understanding the medication regimen?
- ❑ Had recent new/changed orders for medications that require skilled assessment to determine effectiveness of the change?
- ❑ Had recent treatments or multiple change orders over the cert period?
- ❑ Had recent changes in the plan of care indicating further skilled services are needed?

Does the patient have:

- ❑ A high risk for hospitalization due to exacerbation of the disease process?
- ❑ Co-morbidities (such as DM, PVD, renal failure, COPD) which could complicate the wound healing?
- ❑ Ulcer, surgical or other wound that is at risk for a change in condition (positive or negative)?
- ❑ Changes to wound treatment within the past three weeks?
- ❑ A wound that has healed within the past three weeks but remains at **high** risk for recurrence because of co-morbities, for example poorly controlled diabetes, arterial PVD, peripheral edema or end stage renal disease? Additional supporting documentation is required.
- ❑ Teaching needs that have not yet been met?
- ❑ Tasks that have not been demonstrated properly?
- ❑ New problems since the certification period began?
- ❑ Unmet goals or outcomes not reached?
- ❑ Equipment that they are having difficulty managing?

Answering yes to any of the following questions may indicate that skilled assessment and skilled care by **Therapy (PT, OT, and/or SLP)** is medically necessary for patients who have potential to functionally improve.

- ❑ Unable to get on and off toilet.
- ❑ Unable to get in and out of shower/bath safely.
- ❑ Unable to wash body.
- ❑ Unable to prepare a light meal.
- ❑ Unable to ambulate in and out of the home safely.
- ❑ Difficulty eating, chewing and/or swallowing.

Answering yes to any of the following questions indicates continued care under **Management and Evaluation** of the care plan and/or continued care may be medically necessary.

Does the patient have:

- ❑ Complex, non-skilled needs?
- ❑ An unstable or complex caregiver situation?
- ❑ Multiple caregivers involved on a regular basis?
- ❑ Recent changes in the "in-home" care plan for the patient?
- ❑ Risk for becoming unstable due to unmet complex non-skilled needs?
- ❑ Recent changes in the status of caregivers?

Answering yes to any of the following questions may indicate **continued care is not appropriate:**

- ❑ Are instabilities part of a long-standing condition where further changes have not been made to the plan of care?
- ❑ Does the patient remain non-compliant after attempts have been made to educate them on the importance of following the treatment plan and there is documentation of patient's of non-compliance?
- ❑ Is there a lack of measurable progress towards goals (for more than three weeks)?

Comments: PT discharge next week with goals met.
SN discharge next week with goals met,
wound mostly healed.
Patient progress to outpatient for more therapy.

Clinician/Manager Print Name:	Date: 9/8/10
Signature: Kristin Knight	Title: MCP

Recert/Discharge Case Conference

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I- CC1000 03/08

EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert. | Location Name: Milwaukee | Location No.: 0247 | Client No.: 18847

Employee No.: 0153 | Employee Name (last, first): Offman Anne | Patient Name (last, first): Brannon Mary Ann

Pay/Bill Code	Shift	Date of Service (Month / Day / Year)	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
20		9 / 10 / 10	3:45 pm	4:30 pm	3:16 pm	3:44 pm	28	Mileage ___ Bill Mileage ☐ Yes ☐ No

Patient Time	Non-Billable Visit Duration (NBD)	Chart Time	Total Time
Hrs ___ Min 40	Hrs ___ Min ___	Hrs ___ Min 5	1 Hrs 13 Min

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ OT | Override Bill Rates ☐ Yes ☐ No | Override Pay Rates ☐ Yes ☐ No | Payor Code | Bill Units | Pay Units | Bill Rate | Pay Rate | Product Category | Product Code

Supplies: Code / Quantity

Patient Signature: Mary Brannon | Employee Signature: A Offman PTMS OCS | Approved by Initials/Date: 9-14-10

SKILLED OBSERVATION

VITAL SIGNS
T 98.3
P 80
R
Wt
BP ___ right
128/76 left
☐ Standing ☐ Lying ☒ Sitting

Applicable lab/fingerstick values

Last BM:

PAIN
Pain Addendum ☐ Yes ☒ No

Frequency of Pain interfering with patient's activity or movement:
☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often than daily
☒ 2 - Daily, but not constantly
☐ 3 - All of the time

PAIN PROFILE (R) ankle
Intensity: 0 1 2 3 4 (5) 6 7 8 9 10
Location(s): (R) ankle ↑ pain lately - has
Pain Precipitated by: c/o pain most days
Pain Duration:
Pain Relieved by:
Current pain management & effectiveness:
☐ Pain Management Teaching to patient/family (document below) (R) unst 8/10 - pt w/ took brace off ↑ pain - able to move in all directions c̄ pain - AROM 8/ AROM 8-9/10 - going to PT outpt

Medication change since last visit? ☒ No ☐ Yes, Specify

Homebound Status (Describe) unable to follow all precautions 2° unst level - HHS is done next week -

SKILLED ASSESSMENT/INTERVENTION

Assessment relative to problems addressed this visit/new problems identified and services provided: Pt reported to RN this am that yesterday she felt a crack when moving her foot, likely just scar tissue 2° continues to be able to amb on it. pt said it was very swollen yesterday but today is just typical swelling.
2° (L) shd/unst pain - educ pt to ice shd/unst - says she does it 3-4 / already on antiinflammatory meds - needs to rest + ice for now - can begin more active ex as outpt. Could use uspas outpt for ↓ inflamm. - Ankle ROM (R) PROM DF 15°, AROM 8° (R) PF Active 21°, Passive 25° ☐ See Addendum

Supplies Used: inversion Active 10° eversion 5° - ☐ Billing for supplies used by Patient/Caregiver

SKILLED TEACHING / PATIENT RESPONSE

Instructions given to: MMT - DF 4+/5, PF 4/5, inversion 4/5, eversion 4/5

Subject(s) taught:
- Ankle HEP - gave heel rises barefoot x 10 reps
DF standing barefoot x 10 reps - pt already

Patient/Caregiver is able to repeat/demonstrate the following: doing hip exercises standing
tried do single leg heel raises - too difficult yet - needs (B) support yet - also doing SLS foot inside sink - does it c̄ UE support

Teaching plan for next visit: on soft surface.
Pt amb in home, ø device, ø shoes, slight limp + ↓ stance on (R)
Pt verbalizes understanding of all instructions c̄ unst [illegible]

SUPERVISION

☐ Aide ☐ LP(V)N ☐ Other

Present on this visit?	☐ Yes	☐ No
Following care plan?	☐ Yes	☐ No
Compatible?	☐ Yes	☐ No
Report changes in patient status to Office?	☐ Yes	☐ No
Patient satisfied with care?	☐ Yes	☐ No
Changes made to care plan?	☐ Yes	☐ No
Additional instruction given during visit?	☐ Yes	☐ No

Employee Name:

COORDINATION / PLAN

Patients Progress Towards Goal/Goals Resolved this Visit? (specify) unst - pt needs to cont rest/ice/brace

Conferenced With: SN PT OT SLP MSS HHA Other (circle) Name: ankle - doing well c̄ ROM/strength - MMD/c next visit

Regarding:
wrote note to MD for visit next week

Physician Contacted Re: LM c̄ 1° MD (one who ordered outpt PT for (L) shd/unst) re ↑ pain Date/Time 4:20 9/10/10

Physician Response/Result: rec to MD to cont ice/rest/brace - no ex now See Interim Order ☐ Yes ☒ No

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan:

MD Appt Date

Plan for Next Visit: ↓ gt outdoors/steps, reassess re unst to CNSW [illegible]

Discharge Planning: ~~NT~~ ~~HD~~ cont [illegible]

☐ Patient/Caregiver agreed with DC plan

WHITE – Clinical Record YELLOW – Billing

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EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert. | Location Name: M, IW | Location No. 0247

Employee No.	Employee Name (last, first)	Patient No.	Patient Name (last, first)
738	Aiston Patty	18847	Brannon Maryann

Pay/Bill Code	Shift	Date of Service m/d/y	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
010	D	9/10/20	1050 ☒am ☐pm	1125 ☒am ☐pm	1030 ☒am ☐pm	1050 ☒am ☐pm	20	Mileage ___ Bill Mileage ☐Yes ☐No

Patient Time Hrs	Patient Time Min	Non-Billable Visit Duration (NBD) Hrs	NBD Min	Chart Time Hrs	Chart Time Min	Total Time Hrs	Total Time Min

☐Bill/Pay ☐Bill ☐Pay ☐No Pay/No Bill ☐Overtime | Override Bill Rates ☐Yes ☐No | Override Pay Rates ☐Yes ☐No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Patient Signature X Mary A Brannon | Employee Signature Patty Aiston | Validated By Initials/Date [illegible]

Vital Signs

T: 97.2 P: 86 R: 18

Weight: ____ ☐ Gain ☐ Loss Since last visit: ____

BP	Lying	Sitting	Standing
Right:		118/88	
Left:			

☐ Pt/cg self monitoring: ☐T ☐P ☐BP ☐SpO_2

Comments:

Supervision

☐ N/A ☐ Aide ☐ LPN/LVN

Present on this visit: ☐ Yes ☐ No
Name if present:
Following Care Plan: ☐ Yes ☐ No Compatible: ☐ Yes ☐ No
Report changes in patient status to office: ☐ Yes ☐ No
Changes to care plan: ☐ Yes ☐ No
Additional instructions provided during visit: ☐ Yes ☐ No
Comments:

Pain Assessment

Frequency of Pain Interfering with patient's activity or movement:

☐ Patient has no pain ☐ Pain does not interfere with activity or movement
☐ Less often than daily ☒ Daily, but not constantly ☐ All of the time

Pain Rating: 7 /10 Scale Used: ☐ Numeric ☐ FLACC ☐ Faces
Location(s): Brindle Pain Precipitated by:
Pain Duration: off/on Pain Relieved by: PRN meds
Is current pain management effective?: ☒ Yes ☐ No *(explain below)*
Expresses anything

Respiratory

☒ N/A Assessed/Observed the following:

Breath Sounds: ☒ Clear: (R / L) ☐ Wheezes: R / L
☐ Crackles: R / L fine or coarse
☐ Dyspnea at rest and/or supine ☐ Dyspnea with ADLS
☐ Dyspnea on minimal exertion ____ ft/ ____ min
Cough: ☐ Dry ☐ Productive ☐ Hemoptysis
Sputum: color: ____ consistency: ____
Incentive Spirometry: ____ cc
☐ Oxygen ____ L/min ☐ Nasal cannula ☐ Mask
☐ Other ____ ☐ Continuous ☐ PRN
☐ Tracheostomy:
☐ Ventilator:
☐ SpO_2: 95% ☒ No Problems Identified
Comments:

Labs

☒ N/A ☐ VP # Attempts:

Draw/Site:
Test Performed: Lab Delivered to:
Applicable Drug Last Dose/Time:
☐ PT/INR Results:
Results/Comments:

Neurological

☐ N/A Assessed/Observed the following:

☒ Alert ☒ Oriented ☒ Forgetful ☐ Confused ☐ Disoriented
☐ Lethargic ☐ Depressed Weakness: ☐ Right side ☐ Left side
☐ Dizziness ☐ Tremors Paralysis: ☐ Right side ☐ Left side
☐ Headaches ☐ Difficulty Swallowing ☐ Recent Seizure Activity
☒ No Problems Identified
Comments: anxious

Endocrine

☒ N/A Assessed/Observed the following:

☐ Performs own glucose monitoring without problems
Patient reported Blood Sugar range:
☐ Burning/numbness/tingling/loss of sensation of feet
☐ Hypoglycemia ☐ Hyperglycemia
Blood Sugar: ____ mg/dl ☐ Fasting ☐ Random
☐ No Problems Identified
Comments:

Cardiovascular

☐ N/A Assessed/Observed the following:

Heart Sounds: ☒ Regular ☐ Muffled/Distant ☐ Gallop
☐ Irregular ☐ Murmur ☐ Other:
☐ Palpitations ☐ Bradycardia ☐ Tachycardia ☐ Angina
Pedal Pulses Palpable: ☐ Right Side ☐ Left Side
☐ Edema Location: ____ ☐ Abnormal Capillary Refill(>3 seconds) ☐ Pacemaker ☐ AICD
Right: ☐1+ ☐2+ ☐3+ ☐4+ Left: ☐1+ ☐2+ ☐3+ ☐4+
☐ No Problems Identified
Comments:

Nutrition

☐ N/A Assessed/Observed the following:

Diet type: ☐ Regular ☐ Diabetic
☐ Low Fat/NAS/Low Cholesterol ☐ Renal
☐ Other:
☐ Fluid Restriction: ____ /24 hrs ☐ Poor Appetite
☐ Poor Dietary Compliance ☐ Chewing Problems
☐ Lack of Food Available
☐ NG ☐ G-tube/PEG ☐ Jejunostomy
Enteral Feedings: ☐ Continuous ☐ Pump ☐ Gravity
☐ Bolus Type: ____ Rate: ____
☐ No Problems Identified
Comments:

Genitourinary

☐ N/A Assessed/Observed the following:

☒ Voiding without problems
Incontinence: *(type)* ☐ Functional ☐ Stress ☐ Urge ☐ Overflow
☐ Retention ☐ Urine odor ☐ Pain ☐ Burning ☐ Hesitancy
☐ Hematuria ☐ Anuria ☐ Dialysis ☐ Renal Insufficiency/Failure
☐ Nephrostomy: R/L/Bilateral ☐ Self intermittent Catheterization
Catheter Type: ☐ Urethral ☐ SP ☐ External ☐ Other ____ ☐ BSD Bag ☐ Leg Bag
Catheter Change This Visit: ____ size catheter ____ size balloon filled with ____ sterile H_2O
Comments:

Medications

Assessed/Observed the following:

Compliant with regimen: ☒ Yes ☐ No
Available in home as ordered: ☒ Yes ☐ No
New/Changes since last visit: ☒ No ☐ Yes (list below)

☐ Adverse event/reaction/interaction/significant side effects:

Communication: ☐ Physician ☐ Pharmacy
Meds managed by: Pt
Comments:

Gastrointestinal

☐ N/A Assessed/Observed the following:

Date of last BM: 9/10/20 ☐ Oral Lesions, Sores
☐ Abdomen Soft ☐ Bowel Sounds Present ☐ Bowel Sounds Sluggish
☐ Constipation ☐ Bowel Sounds Absent ☐ Incontinence
☐ Bloody/Tarry Stools ☐ Diarrhea ☐ Increased Flatulence
☐ Ileostomy ☐ Abdomen Distended ☐ Self Manages Ostomy
☐ Gum Problems ☐ Colostomy ☐ Other:
☒ No Problems Identified
Comments:

SKILLED NURSING NOTE

Date: 9/10/10 Patient Name: Bannon Patient No. 15847

Integumentary

☒ No Problems identified/Skin intact ☐ Diabetic Foot/Skin Assessment Completed ☒ No S/S of Infection

☐ ______ (site) Surgical Wound Approximated/intact: ☐ Staples ☐ Sutures ☐ Steri-strips ☐ Skin/Surgical Adhesive

Location	Wound Type	Dimensions	Exudated, Amount, Type, Color	Wound Tissue Type (circle % for each type present)	Surrounding Skin, Wound Margins
		L: ____ cm W: ____ cm D: ____ cm Tunneling/Undermining @ ___-___ cm	☐ None ☐ Serous ☐ Yellow ☐ Scant ☐ Serosanguineous ☐ Tan ☐ Small ☐ Purulent ☐ Green ☐ Medium ☐ Foul Odor ☐ Whitish ☐ Large ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ____ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ____
		L: ____ cm W: ____ cm D: ____ cm Tunneling/Undermining @ ___-___ cm	☐ None ☐ Serous ☐ Yellow ☐ Scant ☐ Serosanguineous ☐ Tan ☐ Small ☐ Purulent ☐ Green ☐ Medium ☐ Foul Odor ☐ Whitish ☐ Large ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ____ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ____

Location: ____ Location: ____
Cleansed with: ____ Cleansed with: ____
Dressed with: ____ Dressed with: ____
Packed with: ____ Packed with: ____
Covered with: ____ Covered with: ____
Secured with: ____ Secured with: ____

Pressure Reduction Equipment in Use: ☐ Wheelchair Cushion ☐ Replacement Mattress ☐ Mattress Overlay ☐ Specialty Bed: ____

Comments: ____

Musculoskeletal

☐ N/A Assessed/Observed the following: ☐ Assistive Device(s) in Use: (list) cane

☒ Fall Risk Recent Fall Since Last Visit: ☐ Yes ☒ No ☐ if yes, Clinical Manager/Physician Notified ☒ No problems identified

Comments: ____

Homebound

☒ N/A ☐ Patient is Homebound due to (state in specific measurable and functional terms): ____

Comments: ____

Skilled Instruction - Key: 1 = verbalizes understanding; 2 = return demonstration; 3 = needs further instruction; 4 = goal met

Patient/Caregiver Instruction:	Specify:	1	2	3	4	Patient/Caregiver Instruction:	Specify:	1	2	3	4
☐ 1. disease process						☐ 10. ostomy care/foley care					
☐ 2. S/S complications						☐ 11. bowel/bladder training					
☐ 3. medications						☐ 12. infection control					
☐ 4. IV/TPN						☐ 13. emergency plan					
☐ 5. inhalation/O2 therapy/safety						☐ 14. falls precaution					
☐ 6. pain management						☐ 15. equipment					
☐ 7. wound/decubitus care						☐ 16. anticoagulant precautions					
☐ 8. nutrition/dehydration						☐ 17. hypoglycemic precautions					
☐ 9. diabetic care						☒ 18. Other: dc next visit by SN					

Details of Skilled instruction: Pt instructed SN last visit Mon. Pt [illegible] Wed and reports she is starting outpatient for (L) arm/wrist on that day. Pt agrees c discharge

Additional Skilled Care Provided

☐ See (indicate Note/Addendum): SN [illegible] skin assessment of (R) ankle. Scab

Comments: [illegible] present. Pt continues to wash daily and use alcohol wipe. Pt reports yesterday thinking she twisted ankle yesterday. Pt reports stretching (R) ankle and heard crackling and ankle swelled up. Pt expresses [illegible] today but swelling to (R) ankle is same as last visit. Pt instructed to continue c ice, elevation, and use of tubigrip. Also instructed if worse or pain to go to ER. Pt verbalized understanding

Patient response to care provided: pleased

Supplies Used

____

COORDINATION PLAN

Patient's Progress Towards Goal/Goals Resolved this Visit? (specify) Goal met

Contacted/conference with: Physician SN PT OT SLP MSS HHA Other (circle) Name: Dr Wilson ([illegible]) Date/Time: ____

Regarding: Report pt crackling sound/report ↑ swelling; instructions given to pt

Response: ____ See interim Order: ☐ Yes ☐ No

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan ____ MD Appt. Date ____

Plan for Next Visit: DC

Discharge Planning: next visit

Date: 9/10/10 Patient Name: Bannon Patient No. 15847

Integumentary

☒ No Problems Identified/Skin intact ☐ Diabetic Foot/Skin Assessment Completed ☒ No S/S of infection

☐ ________ (site) Surgical Wound Approximated/intact: ☐ Staples ☐ Sutures ☐ Steri-strips ☐ Skin/Surgical Adhesive

Location	Wound Type	Dimensions	Exudated, Amount, Type, Color			Wound Tissue Type (circle % for each type present)	Surrounding Skin, Wound Margins
		L: ______ cm W: ______ cm D: ______ cm Tunneling/Undermining @ ____-____ cm	☐ None ☐ Scant ☐ Small ☐ Medium ☐ Large	☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor	☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ______ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ______
		L: ______ cm W: ______ cm D: ______ cm Tunneling/Undermining @ ____-____ cm	☐ None ☐ Scant ☐ Small ☐ Medium ☐ Large	☐ Serous ☐ Serosanguineous ☐ Purulent ☐ Foul Odor	☐ Yellow ☐ Tan ☐ Green ☐ Whitish ☐ Other: ____	Red: <25 25 50 75 100 Pink: <25 25 50 75 100 Yellow: <25 25 50 75 100 Black: <25 25 50 75 100 Other: ______ - ___%	☐ WNL/open wound margins ☐ Redness ☐ Swelling ☐ Rash ☐ Macerated ☐ Closed wound margins ☐ Other: ______

Location:	Location:
Cleansed with:	Cleansed with:
Dressed with:	Dressed with:
Packed with:	Packed with:
Covered with:	Covered with:
Secured with:	Secured with:

Pressure Reduction Equipment in Use: ☐ Wheelchair Cushion ☐ Replacement Mattress ☐ Mattress Overlay ☐ Specialty Bed: ______

Comments: ______

Musculoskeletal

☐ N/A Assessed/Observed the following: ☐ Assistive Device(s) in Use: (list) cane

☒ Fall Risk Recent Fall Since Last Visit: ☐ Yes ☒ No ☐ If yes, Clinical Manager/Physician Notified ☒ No problems identified

Comments: ______

Homebound

☒ N/A ☐ Patient is Homebound due to (state in specific measurable and functional terms): ______

Comments: ______

Skilled Instruction - Key: 1 = verbalizes understanding; 2 = return demonstration; 3 = needs further instruction; 4 = goal met

Patient/Caregiver instruction:	Specify:	1	2	3	4	Patient/Caregiver instruction:	Specify:	1	2	3	4
☐ 1. disease process						☐ 10. ostomy care/foley care					
☐ 2. S/S complications						☐ 11. bowel/bladder training					
☐ 3. medications						☐ 12. infection control					
☐ 4. IV/TPN						☐ 13. emergency plan					
☐ 5. inhalation/O2 therapy/safety						☐ 14. falls precaution					
☐ 6. pain management						☐ 15. equipment					
☐ 7. wound/decubitus care						☐ 16. anticoagulant precautions					
☐ 8. nutrition/dehydration						☐ 17. hypoglycemic precautions					
☐ 9. diabetic care						☒ 18. Other: dc next visit by SN					

Details of Skilled Instruction: Pt instructed SN last visit Mon. Pt [illegible] Wed and reports she is starting outpatient for [illegible] on that day. Pt agrees c̄ discharge.

Additional Skilled Care Provided

☐ See (indicate Note/Addendum): SN for skin assessment of (R) ankle. [illegible]

Comments: [illegible] present. Pt continues to wash daily and use alcohol wipe. Pt reports yesterday thinking she twisted ankle yesterday. Pt reports stretching (R) ankle and heard crackling and ankle swelled up. Pt expresses [illegible] today but swelling to (R) ankle is same as last visit. Pt instructed to continue c̄ ice, [illegible] elevation and use of tubigrip. Also instructed if worse ↑ pain to go to ER. Pt verb understanding.

Patient response to care provided: pleased

Supplies Used

______

COORDINATION PLAN

Patient's Progress Towards Goal/Goals Resolved this Visit? (specify) Goal met

Contacted/conference with: Physician SN PT OT SLP MSS HHA Other (circle) Name: Dr Wilson ([illegible]) Date/Time: ______

Regarding: Report pt crackling sound / report ↑ stiffness; instructions given to pt

Response: ______ See Interim Order: ☐ Yes ☐ No

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan ______ MD Appt. Date ______

Plan for Next Visit: DC

Discharge Planning: Next visit

EMPLOYEE TIME SLIP

☒ Cert. ☐ Non-Cert.

Location Name	Location No.	Client No.
Milwaukee	0247	18847

Employee No.	Employee Name (last, first)	Patient Name (last, first)
0153	Hoffman Anne	Brannon Mary Ann

Pay/Bill Code	Shift	Date of Service (Month / Day / Year)	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
20		9 / 13 / 10	10:30 ☒ am ☐ pm	11:15 ☒ am ☐ pm	10:20 ☒ am ☐ pm	10:29 ☒ am ☐ pm	9	Mileage; Bill Mileage ☐ Yes ☐ No

Patient Time	Non-Billable Visit Duration (NBD)	Chart Time	Total Time
Hrs 45 Min	Hrs Min	Hrs 5 Min	Hrs Min

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ OT

Override Bill Rates ☐ Yes ☐ No
Override Pay Rates ☐ Yes ☐ No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Co

Supplies: Code / Quantity

Patient Signature: (x) [signature]

Employee Signature: A Hoffman PTMS OCS

Approved by Initials/Date: [initials] 9-21-10

SKILLED OBSERVATION

VITAL SIGNS

T 98.1
P 84
R
Wt
BP 120/80 right
left
☐ Standing
☐ Lying
☒ Sitting

Applicable lab/fingerstick values

Last BM:

PAIN

Pain Addendum ☐ Yes ☒ No

Frequency of Pain interfering with patient's activity or movement:

☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☒ 1 - Less often than daily
☐ 2 - Daily, but not constantly
☐ 3 - All of the time

PAIN PROFILE [illegible]

Intensity: (0) 1 Low 2 3 4 5 6 7 8 9

Location(s): hurts when she walks a lot,
Pain Precipitated by: doing inversion/eversion - pt
Pain Duration: really wants to walk ē foot in
Pain Relieved by: more neutral, pt tends to ho[illegible]
Current pain management & effectiveness: foot in supination at rest

☐ Pain Management Teaching to patient/family (document below)

Has to stop gait [illegible] >2 blocks
↓ ↑ pain (R) ankle

Medication change since last visit? ☒ No ☐ Yes, Specify

Homebound Status (Describe): 2° cognitive status, pt doesn't do well ē following instructions, overdoes activity +

SKILLED ASSESSMENT/INTERVENTION

Assessment relative to problems addressed this visit/new problems identified and services provided: Pt using unst brace most of the time
pt has 1/10 pain ē brace off, 4/10 ē brace on. Educ pt to cont brace, ice, re[st]
to allow cont healing, ↓ inflammation - will start outpt next wk.

Gait - amb 2 blocks (roundtrip) ≈ 1000-1200' ē std cane - pt amb ē slig[ht]
limp towards end of gait - has good step length, heel strike, good initial
contact ē supination + transition to pronation. Reports some fatigue
@ end of gait attempt. Pt cognitively [illegible]. Pt concerned re:

☐ See Addendum

Supplies Used: transportation to outpt PT but pt is able

☐ Billing for supplies used by Patient/Caregiver

SKILLED TEACHING / PATIENT RESPONSE

Instructions given to: to physically manage outpt PT. Explained again
Subject(s) taught: to pt that lack of transportation does not justify
continued home health services.

Patient/Caregiver is able to repeat/demonstrate the following: ther ex - renewed HEP ē pt - able
to do all standing ex (B) including SLS + heel raises
(B) LE - pt to start outpt next wk for cont (R)
ankle + to begin ē (L) std / (L) unst.

Teaching plan for next visit:

SUPERVISION

☐ Aide ☐ LPN/VN ☐ Other

Present on this visit? ☐ Yes ☐
Following care plan? ☐ Yes ☐
Compatible? ☐ Yes ☐
Report changes in patient status to Office? ☐ Yes ☐
Patient satisfied with care? ☐ Yes ☐
Changes made to care plan? ☐ Yes ☐
Additional instruction given during visit? ☐ Yes ☐
Employee Name:

COORDINATION / PLAN

Patients Progress Towards Goal/Goals Resolved this Visit? (specify) needed to assess longer distance ambulat[ion]

Conferenced With: SN PT OT SLP MSS HHA Other (circle) Name: to ensure that pt can safely go to outpt P[T]

Regarding: Pt very worried that she couldn't tolerate it but is begin[ning]
to realize that she can handle (I) long distance ame[s]

Physician Contacted Re:
Date/Time

Physician Response/Result
See Interim Order ☐ Yes ☐

☐ Changes in the POC discussed with Patient/Caregiver ☐ Patient/Caregiver agreed with plan:

MD Appt.Date

Plan for Next Visit: D/C next visit ō MD appt

Discharge Planning:
☐ Patient/Caregiver agreed with Di[scharge]

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EMPLOYEE TIME SLIP ☐ Cert. ☐ Non-Cert Location Name Milo Location No. 0247

Employee No. 738	Employee Name (last, first) Austin Patty	Patient No. 18847	Patient Name (last, first) Brannon Maryann

Pay/Bill Code	Shift	Date of Service m/d/y	Service Time Start	Service Time Stop	Travel Time Start	Travel Time Stop	Travel Duration	Mileage
010	D	9/13/10	1158 am	1223 pm	1130 am	1158 am	28	Mileage ___ Bill Mileage ☐ Yes ☐ No

Patient Time	Non-Billable Visit Duration (NBD)	Chart Time	Total Time
Hrs ___ Min 25	Hrs ___ Min ___	Hrs ___ Min ___	Hrs ___ Min ___

☐ Bill/Pay ☐ Bill ☐ Pay ☐ No Pay/No Bill ☐ OT
Override Bill Rates ☐ Yes ☐ No
Override Pay Rates ☐ Yes ☐ No

Payor Code	Bill Units	Pay Units	Bill Rate	Pay Rate	Product Category	Product Code

Supplies: Code / Quantity

Supervisory Visit ☐ Yes ☐ No Caregiver Present ☐ Yes ☐ No Name/Discipline___
Change Ancillary Care Plan ☐ No ☐ Yes Patient/RP notified of change (specify)
Patient/Staff Compatible ☐ Yes ☐ No (specify)___
Staff followed CarePlan ☐ Yes ☐ No (specify)___

Patient Signature: Maryann Brannon Employee Signature: Patty Austin RN Approved by Initials/Date: 9-21-10

☒ DISCHARGE VISIT (ON-SITE) ☐ NON-VISIT DISCHARGE/TRANSFER SUMMARY ☐ PROGRESS SUMMARY COVERING PERIOD ___ TO ___ ☐ CASE CONFERENCE

CARE DISCUSSED WITH (NAMES/TITLES): Kristen MCP, Rosie MCP, Andie C PT

SKILLED SERVICES PROVIDED THIS VISIT: Pain (R) LE 3/10. Pox 95% HRR 82, BP 118/78 Temp 97 R16. Lungs CTA. Daily BMs. No problem c urinating. RLE c mild swell. Pt continues to use techniques, elevation, ice, for management. Pt sets up own meds and husband does check because pt forgetful. R lateral ankle c scab 0.3x0.3 and dry peeling skin which is left open. MD will assess if lotion can start [illegible]

SUMMARY OF PATIENT'S CONDITION / SERVICES PROVIDED ON ADMISSION THROUGH DISCHARGE/TRANSFER:
Pt seen for (R) lateral ankle surgical wound care c hx of few infections and cardio/resp/med assessment and instruction due to slow cognition and hx of asthma. MD notified and agrees c dc. Pt will be starting outpatient therapy.

OVERALL STATUS OF GOALS: ☒ GOALS MET ☐ GOALS NOT MET (EXPLAIN): Pt aware to contact MD if any complications further arises and goals met

☐ CLINICAL RECORD REVIEWED ADVANCE DIRECTIVE EXISTS? ☐ YES ☐ NO SPECIFY:

COMPLETE THIS SECTION AT DISCHARGE:

SOC Date:	PRIMARY DIAGNOSIS:	(GH230) ICD	(GH230) Severity Rating (see below)	Other Diagnoses:	D/C/Transfer Date:	LAST DISCIPLINE
6/5/10	Aft Surg wound		☐0 ☒1 ☐2 ☐3 ☐4	Asthma	9/13/10	☐ YES ☒ NO

(GH230) Severity Index
0 - Asymptomatic, no treatment needed at this time.
1 - Symptoms well controlled with current therapy.
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring.
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring.
4 - Symptoms poorly controlled; history of rehospitalizations.

SERVICES PROVIDED AND CLASSIFICATION:

	☒ RN (06)	☐ LP(V)N (18)	☒ PT (10)	☐ OT (12)	☐ SLP (14)	☐ MSW (16)	☐ HHA/PCW (24)	☐ RT (08)	☐ Nutritionist	☐ Other
Number of Visits										

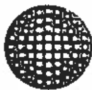
REASON FOR DISCHARGE/TRANSFER

- ☒ 01 Discharge to Home or Self Care
- ☐ 02 Sent to Short-Term Hospital
- ☐ 03 Sent to Skilled Nursing Facility
- ☐ 04 Sent to Intermediate Care Facility
- ☐ 05 Sent to a Different Type of Institution
- ☐ 06 Sent Home with a Different Provider
- ☐ 07 Left Against Medical Advice
- ☐ 09 Family/Friends Assume Responsibility
- ☐ 10 Sent to Outpatient Rehab
- ☐ 11 Transferred by Doctor Request
- ☐ 12 Discharge for Lack of Progress
- ☐ 13 Discharged for Lack of Funds
- ☐ 14 Discharged for Other Reason
- ☐ 15 Patient Moved Out of Area
- ☐ 16 Patient Has Achieved Maximum Rehab Possible
- ☐ 17 Patient/Family Non-Compliant
- ☐ 18 Patient No Longer Homebound
- ☐ 19 Patient Refuses Further Services
- ☐ 65 Discharge to Psych Hospital
- ☐ 20 Expired
- ☐ 40 Expired at Home
- ☐ 41 Expired in Hospital, SNF, ICF
- ☐ 42 Expired, Place Unknown
- ☐ 50 Discharged to CHHA
- ☐ 51 Discharged to Long Term Care Facility
- ☐ 52 Discharged to Long Term Care Home Care Age
- ☐ 53 Discharged to Department of Social Services
- ☐ 54 Discharged to Community Agency

TRANSFER TO:___ REFERRALS MADE ☐ YES ☐ NO SPECIFY:___

Sent To: ☐ Physician ☐ Case manager ☐ D/C Planner ☐ Facility ☐ Other Date:

Physician Signature (If Required): Date:



GENTIVA®
orthopedics

PATIENT PROGRESS REPORT

(Circle one) PT

Physician Dr Wilson		Diagnosis/ Procedure (R) ankle ORIF	
Patient Name Brannon Mary Ann		DOB	Patient # 18847
Patient Comments			Pain (0-10) Scale usually 0/10 – occ 4-5/10 when she over does walking/ ac
Observation	pt doing very well c̄ all function mobility – is not really homebound – could manage outpt PT p̄ this week.		
ROM / Strength	Rom (R) ankle DF active 8°, passive 15°, PF active 21°, passive 25°, inversion active 10° eversion active 5° – MMT – DF 4+/5, PF 4/5, inv. 4/5 ever. 4-/5		
Ambulation / Transfers	(I) c̄ cane indoors/ outdoors – if amb. too far (> 2 bl gets fatigued, can do steps (I) Amb mostly c̄ shoes on, occ c̄ shoes off		
Function	(I) c̄ all ADLs, IADL's – transportation is 1° limitation		
Therapist Comments	pt should begin outpt next wk for (L) should inst – Dx'ed c̄ (L) shd sprain + (L) wrist sprain. – have had pt rest/ice/brace – needs US/ex if pain cont		
Plan	☒ Complete remaining (1) visits per plan – D/C 9/16 – just want to ensure follow up as need p̄ MD appt ☐ Extend current orders by (____)visits for (____) weeks ☐ D/C Patient at this time to (self care) (outpatient PT) (Circle one) ☐ Other________		
Therapist Name (Print)	Anne Coffman		
Therapist Signature	ACoffman PT MS OCS	Date 9/10/10	
Phone Number	414-550-7677	Fax Number	

PHYSICIAN ORDERS/ COMMENTS:

☒ Approve plan as above — refer as outpatient
☐ Change plan as follows

Physician Signature: [signature] Date: 9/15/10

White – Clinical Record
Yellow -- Clinician

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GCL3018 created 2/08

DISCHARGE NOTICE (WISCONSIN)

Patient Name: Brannon, Mary Anne Patient #: 17847

Gentiva Health Services would like to inform you that home care services will end effective 9/16/10.

The reason for discharge is:

- [x] Goals of treatment have been met.
- [ ] Services are being discharged per patient or patient's legal representative request.
- [ ] The patient no longer needs home health care as determined by the attending physician or advanced practice nurse.
- [ ] Gentiva is unable to provide the care required for the patient due to a change in the patient's condition that is not an emergency.
- [ ] The attending physician or advanced practice nurse has ordered the discharge for emergency medical reasons.
- [ ] The safety of staff is compromised.
- [ ] Following a reasonable opportunity to pay any unpaid bills, payment has not been made for patient care provided.

A complaint may be filed by writing the Bureau of Health Services, Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969 or by calling the Wisconsin Home health Hotline toll free at 1-800-642-6552.

Patient Signature: [signature] Date: 9/16/10

Employee Signature: [signature] PTMSGCS Date: 9/16/10

WRITTEN NOTICE OF CIRCUMSTANCES OF CLAIM PURSUANT TO SECTION 893.80(1)(a), WIS. STATS.

CITY OF MILWAUKEE
10 JUL 30 AM 10:51
RONALD D. LEONHARDT
CITY CLERK

To: City of Milwaukee
200 East Wells Street
Milwaukee, Wisconsin 53202

Served upon City Clerk pursuant to Sec. 801.11(4)(a)(3)

NOTICE OF CIRCUMSTANCES OF CLAIM as required by Section 893.80(1)(a), Wis. Stats., is hereby served upon the City of Milwaukee that Mary Ann Brannon suffered personal injuries and has a claim therefore under the following circumstances:

1. That Mary Ann Brannon is an adult residing at 2092 South 102nd Street, Apartment 109, West Allis, Wisconsin 53227.

2. That on or about the 2nd day of June, 2010, at approximately 12:00 p.m., Ms. Brannon suffered injuries while walking on the sidewalk directly in front of the Marcia P. Coggs Human Services Center located at 1220 West Vliet Street, Milwaukee, Wisconsin, when she tripped on the in-ground planter that is on the sidewalk and fell, causing injuries to her.

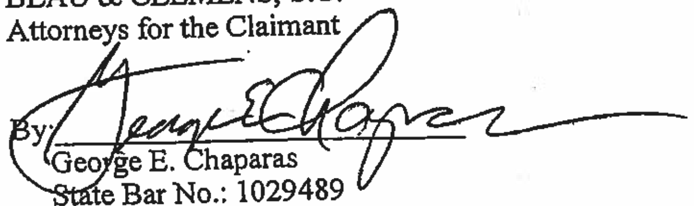
3. That as a direct and proximate result of the City of Milwaukee's negligence in said planter's poor design and/or maintenance which caused said planter to not be level with the sidewalk.

4. That as a direct and proximate result of the City of Milwaukee's negligence, Ms. Brannon was caused to suffer personal injuries including, but not limited to, a broken right fibula, broken right ankle and bruised left ankle, as well as other injuries.

PLEASE TAKE NOTE that this is a **Notice of Circumstances of Claim**, Section 893.80(1)(a), Wis. Stats. It is not a claim under Section 893.80(1)(b), Wis. Stats. Therefore, there is nothing for the City of Milwaukee to allow or disallow with respect to this document. After Mary Ann Brannon's treatment is completed and her injuries are evaluated, we will present a claim under Section 893.80(a)(b), Wis. Stats. for the City of Milwaukee to allow or disallow as it sees fit. There is no requirement that Mary Ann Brannon must file a claim, as opposed to a **Notice of Circumstances of Claim**, within 120 days of her June 2, 2010, injury. See Figgs v. City of Milwaukee, 121 Wis.2d 44, 357 N.W.2d 548 at 522 (1984).

Dated at Milwaukee, Wisconsin this 20th day of July, 2010.

WEIGEL, CARLSON,
BLAU & CLEMENS, S.C.
Attorneys for the Claimant



By: George E. Chaparas
State Bar No.: 1029489

P. O. ADDRESS:
3732 West Wisconsin Avenue, Suite 300
Milwaukee, Wisconsin 53208-3153
Phone: (414) 342-1000