FAIRLAWN REHABILITATION HOSPITAL

HEALTHSOUTH AFFILIATE

INTERDISCIPLINARY DISCHARGE INSTRUCTIONS

Patient Name: Marcia Rhodes **Discharge Date:** 4/16/02

Discharge Address *(if different from admission address):*

Discharge Destination/Level of Care:

- ☐ Home (without Home Health)
- ☑ Home (with Home Health)
- ☐ Acute
- ☐ Assisted Living Facility
- ☐ Chronic Care Facility
- ☐ Transitional Living Facility
- ☐ Skilled Nursing Facility
- ☐ Rehab Facility
- ☐ Other:

Discharged with *(Care Provider)*: VNA of Greater Milford

- ☐ **Outpatient Services**
  - ☐ Day Treatment
  - ☐ Physical therapy
  - ☐ Occupational therapy
  - ☐ Speech Therapy
  - ☐ Neuropsycology
  - ☐ Nursing Services
  - ☐ Other:
- ☑ **Home Health Services**
  - ☑ Physical therapy
  - ☑ Occupational Therapy
  - ☐ Speech therapy
  - ☑ Nursing
  - ☑ Home Health Aide 5xwk repeat
  - ☐ Social Work
- ☑ **Lab Work Follow-Up**
  - ✱ PT/INR - M/Th - to be drawn by nurse from VNA ✱

Name: VNA of Greater Milford
Address PO Box 8
Newton, NH
Telephone: 508 473-0862

APPOINTMENTS SCHEDULED

Service	Provider	Date	Time	Location
physiatry follow up	Dr Gray	6/13/02	10:00 am	Fairlawn Rehab out pt 508-791-6351 x 187

APPOINTMENTS PATIENTS MUST SCHEDULE

Service	Provider	Date	Time	Location
medical follow up	Dr Krantz	- call within 1-2 weeks for follow up appt.		
surgical follow up	Dr Benca	- will call with appt (to be seen w/in 6 weeks)		

OTHER SERVICES RECOMMENDED

Service	Provider	Telephone #
private duty companion	Homewood	797-0402
medical equipment	Medi Rents	617-247-1000
temporary splint	Hanger Prosthetics	508-791-8659

SPECIAL INSTRUCTIONS FOR PATIENT/CAREGIVER

$10 copay per each visit from VNA (for p.t., o.t., nursing, labs)

✱ VNA to call lab results to Dr Krantz - her office will call with follow up done

If you have problems/questions, call (508) 791-6351, Ext. 187

Patricia Grely
Case Manager's Name

Marcia Rhodes
Signature of patient or patient representative

Witness

4/16/02
Date

If no signature, why:

MR 621/1-3-2000

Patient Care Referral Form

Patient's Hospital Record # ____________

FROM: Fairlawn Rehab

Unit/Clinic: 3 North

ADDRESS: 189 May St

Worcester TEL. 791-6351

ADM. DATE: 2/5/02 DISCH. DATE: 4/16/02

TO: VNA of Greater Milford

ADDRESS: P.O Box 8

Mendon MA TEL. 473-0862

PATIENT NAME: [illegible]

ADDRESS: [illegible] TEL. 508-473-6049

FLOOR / APT. # / BIRTHDATE

AGE / SEX / MARITAL STATUS / RELIGION

RELATIVE OR GUARDIAN: [illegible] spouse

ADDRESS: S/A

TEL. 473-6049

MEDICARE NO. & LETTER	PLAN A B	BLUE CROSS NO.	SOC. SEC. NO.	OTHER

CLINIC APPOINTMENTS DATE TIME: Dr Brisson - 6 week F/U

Agency Worker Office Address Telephone

DIAGNOSIS (S) Surgery Performed and Date, Allergies or Infections

MVA → T12 burst fx, multiple rib fx, paraplegia DVT (Greenfield filter)

diabetes insipidus 2° lithium use MRSA pneumonia C diff colitis bipolar disease

GERD

Is Patient Family aware of diagnosis?

Date of last physical

PHYSICIAN'S ORDERS: (Include specific orders for Diet, Lab Tests, Speech, and O.T.)

TRANSPORT BY: ☐ Ambulance ☐ Car

MEDICATION	STRENGTH AND FREQUENCY	DATE & TIME OF LAST DOSE
combivent MDI ii puffs qid	vallum 5 mg po qam	
prozac 20 mg po bid	reglan 10 mg po qid (ac + hs)	
vitamin C 500 mg po bid	coumadin 5 mg po qd	
methenamine mandelate 1g po bid	cylert 75 mg po bid	
wellbutrin 150 mg po bid	ritalin 10 mg po tid prn	
multivitamin c Fe ii po qd	percocet 5/325 1-2 po q4° prn	
prevacid 30 mg po bid	dulcolax suppository i pr daily	
valium 15 mg po qhs		

TREATMENTS & FREQUENCY: Zn Oxide to sacrum

Foley catheter, change monthly PT/INR M + Thurs

Moon boot to L foot when in bed results to Dr Krauth 508-634-9962 (pcp)

fax 508-478-2190

DIET: regular

PHYSICAL THERAPY: Restrict Activity ☐ Yes ☐ No Sensation Impaired ☒ Yes ☐ No

Precautions Weight Bearing Status - Non-Weight ☒ Partial-Weight ☐ Full-Weight ☐

SPECIFIC TREATMENT & FREQUENCY: \ paraplegic

ANTICIPATED GOALS:

REHABILITATION POTENTIAL IS: Good

HOME HEALTH SERVICES: ☒ NURSING ☒ OCC. THERAPY ☐ SPEECH THERAPY ☐ SOCIAL WORK ☒ H.H. AIDE ☒ OTHER-SPECIFY PT

The above services require Level of Care: ☐ I ☐ II ☐ III ☐ IV

If Chronic Hospital, Why?

CERTIFICATION: * (when applicable)
Services above needed to treat condition for which patient was hospitalized ☐ Yes ☐ No
I certify that the above named patient is: (check one)
☐ Under my care (or has been referred to another physician having professional knowledge of patient's condition); is home bound except when receiving out-patient services; requires skilled nursing care on an intermittent basis or physical or speech therapy as specified in the orders.
☐ Requires skilled nursing care on a continuing basis for any of the conditions for which he/she

[signature] M.D.
Signature

David DeGiro M.D.
Print Name

508-791-6351

Tel. ________ Date 4/16/02 Will follow ☐ Yes ☒ No - If no, who?

Dr Krauth - pcp M.D.

ADDRESS: ________ TEL. 508-634-9962

Dr Brisson orthopedist

APPROVED BY THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

MC 71

APR-16-2002 13:48 5 NORTH ORTHO GERI

Fairlawn Rehabilitation Hospital
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1704529 15502605

Name RHODES, MARCIA
11 JANOCK RD MILFORD M.
Record # 06/22/55 F 046 ...
Transfer to: COMMERCIAL 312224914-...
02/05/02 DEGRAND, DAVID

NURSING: Self Care Status Check Functional Level		Independent	Needs Assistance	Unable
Ambulation	Bed-Chair		✓	
	Walking			✓
	Stairs			✓
	Wheelchair	✓		
	Crutches			✓
	Walker			✓
	Cane			✓
Activities	Bathe Self		✓	
	Dress Self		✓	
	Feed Self	✓		
	Brushing Teeth	✓		
	Shaving			
	Toilet			
	Commode			
	Bedpan / Urinal			

Bowel & Bladder Program ☐ Yes ☐ No
Incontinence: ☐ Bladder ☒ Bowel
Date of Last Enema Supp @ HS
Catheter: Type Foley #16 S...
Date last changed:
Weight Height Date
Anointed ☐ Yes ☐ No Date

Check if Pertinent: (describe at right)

DISABILITIES
☐ Amputation
☐ Paralysis
☐ Contractures
☐ Decubitis
☐ Other

IMPAIRMENTS
☐ Speech
☐ Hearing
☐ Vision
☐ Sensation
☐ Other

COMMUNICATION
☐ Can Write
☐ Talks
☐ Understands Speaking
☐ Understands English
☐ If no, Other Language?
☐ Reads
☐ Non-Verbal

BEHAVIOR
☐ Alert
☐ Forgetful
☐ Noisy
☐ Confused
☐ Withdrawn
☐ Wanders
☐ Other

REQUIRES
Mark "S" if sent; "N" if needed
☐ Colostomy Care ☐ Dentures
☐ Cane ☐ Eye Glasses
☐ Crutches ☐ Hearing Aid
☐ Walker ☐ Prosthesis
☐ Wheelchair ☐ Side Rails
☐ Other

PATIENT CARE PLAN

(Explain details of care, medications, treatment, teaching, habits, preferences, and goals.)

Medications: Note time last dose given on day of discharge.

Marcia is a very pleasant 46 year young lady. She was adm to FRH on 2/5/2 c Dx s/p T12 burst Fx sec to MVA, T12 Fx resulted in paraplegia, Also multiple rib Fx. DVT (Greenfield filter) GBKO, diabetes insipidus 2° Lithium use, MRSA pneumonia c L ... PNX. Bipolar Dx. s/p appendectomy, hernia repair.
At present she is Alert + oriented x 3. Ind c feeding, grooming c ↑ body hygiene, dressing. Total assist c ↓ body hygiene + dressing. Need assist c bed mobility, transfers from bed → w/c c versa via sliding board + mod assist.

SKIN: Ind c w/c mobility.
B + B. Foley cath → TKSO cont. Bowel program; Dulcolax supp QH + dig stim if needed. inc of Bowels. Last BM on 4/15/2.
Skin: ... peri intact clear. Buttocks R excoriated + sl redness → peri area. Sm necrotic area - L lateral metatarsal.

Signature of Nurse
Telephone Date

NUTRITION: (discuss food preferences, understanding of diet, teaching needs and goals) Diet enclosed ☐ Yes ☐ No

Lactose free diet, feeds self appetite good.

Nutritionist Signature Telephone Date

CASE MANAGEMENT:

508-791-6351 x 187 4/16/02

Case Manager Signature Telephone Date

Pt is a neuropsych... sustained injury in an MVA (hit by a truck). Lives at home c husband and 14 y.o. dtr. Pt ...

MR620/2-12-97

APR 16 2002 15:45 5 NORTH ORTHO GER.

Patient Care Referral Form
Fairlawn Rehabilitation Hospital
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PHYSICAL/OCCUPATIONAL THERAPIES
Mobility and Self Care

1008539 15... 2605
RHODES, MARCIA
JANOCK RD MILFORD N
06/22/55 F 046
COMMERCIAL 3126...
03/05/02 DEDRA..., DAVID
PATIENT STAMP

	Max	Mod	Min	S	Mod I
Bed Mobility		X			
Bed <--> Chair Transfers	X (uphill)		X (downhill)		
Ambulation	N/A →				
Stairs	N/A →				
Eating					✓
Grooming				~~✓~~	✓
Toileting	Dep				
Bathing		✓			
Dressing UB				✓	
Dressing LB		✓			
Toilet Transfer	max x2				
Tub/Shower Transfer N/A	→				
Homemaking w/c level			✓		

Wt. Bearing: N/A
Type: Sliding Board
Distance & Device: N/A
#: ↓

All fxal activities are performed @ bed level or w/c level. Pt educated on self care while sitting bed level. Pt needs (A) c̄ (L) leg 2° to Ed... Pt educated on use of thigh loop and leg lifters for leg mobi... Pt's husband and caregiver ed... in transfers.
W/c mob x250' + mod... - CTG ↑↓ ramp (1" ↔ 1

Gait Deviations: N/A
Bracing or Adaptive Equipment: leg loops & leg lifter, reacher issued. LSO from Hanger Orthotic (508) 791-...
D/C Equipment & Vendor: ROHO (on order); w/c; and SB from Medicents
Driving/Community Reintegration: NA @ this time, pt needs education on driving new HA van.
Endurance: Poor
Teaching - Bed mob, transfers, and w/c management educ completed c̄ pt's husband (4/9/02) and pt's caregiver @ home (4/12/02).

UE/LE Function
Tone: (B) UE WFL's. (B) LE - FLACCID

Left WFL	Left Impaired		Right WFL	Right Impaired	Describe Impairments:
✓		Shoulder	✓		≥4/5 (B) UE
✓		Elbow	✓		↓
✓		Wrist/Hand	✓		↓
-5°	Hip	Hip		X	0/5 (B) LE's
90°	knee	Knee		X	↓
-5°	DF	Ankle		X	↓

Visual Perceptual Ability: WFL's c̄ glasses.

For permanent w/c - w/c eval can be completed through Medicents (617) 247-1000 for insurance coverage OR through FRH (508) 791-6351 but will ~~not~~ be covered by insurance.

Recommendations: Continued OT for ADL's, Fx transfers, (B) UE str/END, Toileting, homemaking @ w/c level.
Continued PT for SB xfers, bed mobility, (B) LE stretching, sit balance and w/c mgmt.

Signature & Date: [signature] MOTR/L 4/15/02
Signature & Date: Carolyn [signature], PT 4/15/02

Patient Care Referral Form
Fairlawn Rehabilitation Hospital
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PHYSICAL/OCCUPATIONAL THERAPIES
Mobility and Self Care

2004534 1585UC805
RHODES, MARCIA
11 JANOCK RD MILFORD M.
06/22/55 F 046 JEWS M
COMMERCIAL 312684416-01
02/05/02 PATIENT STAMP OLSHANSKY, DAVID

	Max	Mod	Min	S	Mod I
Bed Mobility					
Bed <--> Chair Transfers					
Ambulation					
Stairs					
Eating					
Grooming					
Toileting					
Bathing					
Dressing UB					
Dressing LB					
Toilet Transfer					
Tub/Shower Transfer					
Homemaking					

Wt. Bearing: N/A
Type:
Distance & Device
#:

Additional information:

~~Gait Deviations:~~ * pt will difficulty leaning fwd for xfers 2° fear of falling. Pt requires signif. repetition & grasping new ideas.
~~Bracing or Adaptive Equipment:~~
~~D/C Equipment & Vendor:~~
~~Driving/Community Reintegration:~~ Pt has many Ψ and family issues which also impacts pt's ability to focus on a task
~~Endurance:~~ Pt has difficulty pushing self to complete tasks if obstacles are present or any kind.

~~UE/LE Function~~ Tone:

Left WFL	Left Impaired		Right WFL	Right Impaired	Describe Impairments:
		Shoulder			
		Elbow			
		Wrist/Hand			
		Hip			
		Knee			
		Ankle			

~~Visual Perceptual Ability:~~ Pt's w/c is temp. w/c until pt's sitting balance improves for permanent w/c. Insurance will cover w/c if ordered and eval'd through Medients (617) 247-1000. Initial date
~~Recommendations:~~ was set @ 5/2/02, but please call to confirm. Can call FRH w/c clinic if pt prefers (508) 791-6351 ext. 592 but insura will not cover. Please call when issues arise.

~~Signature & Date:~~ (508) 791-6351 ext. 592 Signature & Date: Carolyn A Gagnon, 4/15/02

MR620 / 3.12.97

FAIRLAWN REHABILITATION HOSPITAL

COUMADIN FLOW SHEET

Patient Addressograph

Diagnosis: DVT

Desirable Range INR 2-3

PT

Physician: DeGrand

Date						4/5	
INR						1.66	
PT							
Dose	5	5	2.5	7.5	5	2.5	2.5

Date							
INR			1.59			2.22	
PT							
Dose	2.5	2	7.5	3	3	4	4

Date							
INR		1.66					
PT							
Dose	4	5	5				

Date							
INR							
PT							
Dose							

Date							
INR							
PT							
Dose							

GF#:230/10-2000

☒ **NARRATIVE NOTE** PATIENT NAME : Rhodes, Marcia

☐ **H.H.A. SUPERVISION** (WITHOUT SKILLED VISIT) ID #: DOB 6-22-1955

(1) Spoke to Pat Catlas (United Health Care) at 401-732-7349 Informed her of Services ordered from Rebok SN, PT, OT, HA and MSW and SOC 4-17-02. Pat will call Back in Am of 4-17-02 ē Auth # and Billing Address

(2) Pat acknowledged that Patient has a $ 10.00 Co-pay on all with but feels Patient is doing well financially and this will not be a problem. United Health will not Pay for S.W unless help ē Community Resources needed

(3) For Further ~~Rec~~ Authorizations call 1-800-822-3807 prompt 6640

☐ **HHA SUPERVISION:**

☐ Q 2 WK. SUPERVISION OF AIDE. PROVIDING SAFE CARE AND FOLLOWING CARE PLAN APPROPRIATELY

☐ ORIENTATION OF AIDE. WRITTEN CARE PLAN AND INSTRUCTIONS GIVEN. ☐ AIDE PERFORMANCE DISCUSSED WITH PATIENT / FAMILY. ☐ SATISFIED WITH CARE.

☐ AIDE PRESENT: ☐ YES ☐ NO

SIGNATURE / TITLE: Kathleen Calcia DATE: 4-16-02

YNAC - 061