HomeCentris Healthcare LLC 217058
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
Phone: 410-321-8448 Fax: 410-559-3002

PHYSICIAN VERBAL ORDER (487)

DATE ORDER CREATED: 08/28/2026	**PATIENT INFORMATION**
ORDER ID: 1150/21542	**PATIENT NAME:** Clemmerose Conaway / **DOB:** 06/18/1935
AGENCY ASSIGNED ID: 22815	**ADDRESS:** 1308 Vida Drive, GWYNN OAK, MD 21207-
CERTIFICATION PERIOD: 07/21/2026 to 09/18/2026	**PHONE:** 410-382-0244
PHYSICIAN FACE-TO-FACE DATE: 07/05/2026	

ORDERS

CLINICAL CONDITION REQUIRING HOME CARE PER CERTIFYING PHYSICIAN:
The patient is a 91-year-old female admitted to home health services following an extended rehabilitation stay at Saint Elizabeth's. She is alert and oriented to person and place, requiring verbal cues for time orientation. Her past medical history is significant for cerebrovascular accident (CVA), recurrent falls, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), chronic arthritis, chronic pain, lymphedema, peripheral vascular disease (PVD), asthma, osteoarthritis, spinal stenosis, hypertension, and right total knee arthroplasty. The patient is considered homebound due to significant functional limitations related to her medical conditions, recent decline in mobility, history of falls, impaired balance, decreased endurance, weakness, and anxiety with ambulation. She requires the use of a rollator and assistance from another person to safely leave the home, and leaving the home requires a considerable and taxing effort. Assessment revealed intact skin, clear bilateral lung sounds, regular heart rhythm with S1 and S2 present, active bowel sounds, and +2 pitting edema to bilateral lower extremities extending into the feet and lower legs. The patient reports bilateral hip pain, toe pain and tingling, and cloudy urine; the primary care provider will be notified for further evaluation. She demonstrates decreased strength (BLE MMT 3-/5), impaired balance, reduced endurance, and requires minimal assistance for transfers and short-distance ambulation with a rollator. Education was provided regarding fall prevention, home safety, edema management, pain management strategies, medication compliance, and positioning techniques to improve comfort and safety. The patient would benefit from continued skilled nursing, physical therapy, and occupational therapy services to address disease management, strength, balance, functional mobility, ADL

address disease management, strength, balance, functional mobility, ADL performance, and safety in order to maximize independence and support her ability to remain safely at home. Date of Order 07/21/2026 Physician Face-to-Face Date: 07/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Other specified chronic obstructive pulmonary disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home 1 - SOC - SN Notes: PT Eval Notes: OT Eval Notes: Physician: Carey, Lisa

HOMEBOUND STATUS PER CERTIFYING PHYSICIAN: Due to diagnosis of Other specified chronic obstructive pulmonary disease, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device

ORDER DETAILS

#	ORDER / INSTRUCTIONS
1	Authorization changes of PT skill Total Visits: 6 and Visit Freq: WK3: 2 (08/30/26-09/05/26),WK4: 2 (09/06/26-09/12/26),WK5: 2 (09/13/26-09/17/26)
2	Authorization changes of SN skill Total Visits: 1 and Visit Freq: WK3: 1 (08/30/26-09/05/26)
3	Authorization changes of OT skill Total Visits: 5 and Visit Freq: WK3: 2 (08/30/26-09/05/26),WK4: 2 (09/06/26-09/12/26),WK5: 1 (09/13/26-09/17/26)

PHYSICIAN INFORMATION

PHYSICIAN NAME: Lisa Carey, MD

ADDRESS: 7505 Osler Dr #305, Towson, MD 21204

PHONE: 4104272020	**FAX:** 14104272013

VERBAL ORDER AUTHORIZATION

By signing below, I acknowledge the verbal order(s) above and agree to follow this plan of care.

PHYSICIAN SIGNATURE	STAFF SIGNATURE (RECEIVED BY)
Signature: _____	Signature: *Electronically Signed by Messick, RN, Charles*

Date: _____	Date: *08/31/2026*

IMPORTANT: This verbal order must be authenticated by the physician and maintained in the patient's medical record.