HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022118

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
7NG2WF0FM83	09/16/2026	09/16/2026 - 11/14/2026	30251	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Sarah Albertines 2621 Ebony Road Parkville, MD 21234	Female	01/25/1951	410-663-2311
	Email		Primary Language: English

Clinical Profile

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

Clinical Condition Requiring Homecare:

The patient is a 75-year-old female referred to home health services following a recent hospitalization and subacute rehabilitation stay for atherosclerosis of arteries RLE with a right heel ulcer and recent cellulitis. Past medical history is significant for atrial fibrillation managed with warfarin therapy, chronic kidney disease stage 3, type 2 diabetes mellitus, peripheral arterial disease/peripheral vascular disease with chronic right foot/toe wounds, status post right hallux fixation, congestive heart failure, hyperlipidemia, and gastroesophageal reflux disease. The patient is alert and oriented x4 and ambulates with a walker. Her daughter, Lisa Cunningham, is the primary caregiver. The patient currently sleeps on the couch in the living room because she is unable to safely negotiate the stairs and uses a bedside commode/BSC on the main floor due to the absence of a bathroom on that level. The right foot wounds are being managed by the podiatrist. Current wound care orders are to cleanse the right foot, including the areas between the 3rd, 4th, and 5th toes and the heel, with normal saline; apply Betadine wet-to-dry dressing; secure with Kerlix; and change the dressings three times weekly on Monday, Wednesday, and Friday. Wound care teaching was provided to the patient's daughter, Lisa, who verbalized understanding of the prescribed wound care regimen. Medication review was completed with the patient, with reinforcement of medication compliance. The patient is on warfarin therapy, and INR was obtained with a result of 5.2. A message was left for the PCP regarding the elevated INR result, and response is pending. The patient has 3 mg, 2 mg, and 1 mg warfarin tablets available in the home. The patient was also instructed regarding right foot elevation to assist with management of edema. She has diabetes but does not currently monitor her blood glucose because she does not have a glucose monitoring machine. Continued skilled nursing follow-up is indicated for wound assessment and care, medication management, monitoring for complications related to anticoagulation and chronic disease conditions, and reinforcement of

Physician Statement on Homebound Status:

Due to diagnosis of Atherosclerosis of the native arteries of the right leg with an ulcer on another part of the foot, 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.

patient/caregiver education. The patient resides in a two-story home with approximately 10 steps to enter and a single railing. Her grandsons live with her, and another individual rents the basement. Prior to her recent hospitalization, the patient reported that she was independent with basic self-care, functional transfers, functional ambulation, and activities of daily living, although she described herself as "wobbly" while walking and reported several falls. The patient currently uses a bedside commode on the main floor because there is no bathroom on that level. The home was observed to be dirty and cluttered, with extension cords across walkways creating an increased fall hazard. A cat is also present in the home. The patient demonstrates impaired balance, with a Tinetti score of 10/28 and a TUG time of 26 seconds. She demonstrated moderate unsteadiness while ambulating with a rolling walker, at times standing outside the walker, with a discontinuous step pattern and wide base of support. She also demonstrates lower-extremity weakness, mild difficulty with transfers, and significant difficulty negotiating stairs, ascending on her hands and knees and descending on her buttocks with moderate unsteadiness. Skilled physical therapy is indicated to address lower-extremity weakness, impaired balance, gait abnormalities, transfer difficulties, stair negotiation, fall risk, and overall functional mobility, with the goal of improving safety and maximizing functional independence in the home. The patient also presents with decreased standing balance, standing tolerance, bilateral upper-extremity strength, and activity tolerance, resulting in decreased independence with self-care, functional transfers, and functional ambulation. Skilled occupational therapy is recommended to address these functional deficits and promote safe performance of activities of daily living, transfers, mobility, and other essential tasks in the home environment. An OT evaluation was attempted but could not be completed because the patient was unable to provide entry into the home and reported that she was unable to ambulate to the front door. The patient agreed to a rescheduled OT evaluation on Monday. Continued skilled OT services are indicated to address the patient's decreased standing tolerance, balance, upper-extremity strength, and activity tolerance and to facilitate return toward her prior level of functional independence.

Date of Order
09/16/2026
Orders
Physician Face-to-Face Date: 09/10/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Atherosclerosis of the native arteries of the right leg with an ulcer on another part of the foot
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: soc PT Eval Notes: OT Eval Notes: Physician Varghese, Jisha	

ICD-10 CM Principal Diagnosis: I70.235. Athscl native arteries of right leg w ulcer oth prt foot

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
L97.512	Non-prs chronic ulcer oth prt right foot w fat layer exposed	Warfarin Sodium - Warfarin Sodium 2.5 MG / 1 Tablet by mouth at bedtime every Mon, Wed, Fri for afib Warfarin Sodium - Warfarin Sodium 0 Give 2 MG Tablet by mouth at bedtime every Tue, Thu, Sat, Sun for A Fib SENNOSIDES 8.6 MG Tablet / Give 2 tablet by mouth two times a day for bowel regimen hold for loose stools Proair Hfa - Albuterol Sulfate Inhalation Aerosol Solution 108 (90 Base) MCG/ACT / Inhale 1 puff by mouth every 6 hours as needed for Wheezing MELATONIN 10 MG / 1 Tablet by mouth at bedtime for Insomnia Lidocaine Patch - Lidocaine 4 % / Apply to right shoulder topically one time a day for pain and remove per schedule Levothyroxine Sodium - Levothyroxine Sodium 88 MCG / 1 Tablet by mouth in the morning for Hypothyroidism Insulin Glargine Subcutaneous Solution 100 UNIT/ML / Inject 30 unit subcutaneous at bedtime for DM Gavilax Powder (Polyethylene Glycol 3350) 0 Give 17 gram by mouth once a day for Bowel Regimen mix with 4 ounces water and hold for loose stools FENOFIBRATE 48 MG / 1 Tablet by mouth one time a day for HLD Escitalopram Oxalate - Escitalopram Oxalate 10 MG / 1 Tablet by mouth one time a day for Depression EMPAGLIFLOZIN 25 MG / 1 Tablet by mouth once a day for DM BIOFREEZE 0 Cool The Pain External Gel 4 % / Apply to Both knees topical once a day for Pain Management Atorvastatin Calcium - Atorvastatin Calcium 40 MG / 1 Tablet by mouth in the evening for HLD Allopurinol - Allopurinol 300 MG / 1 Tablet by mouth once a day for Gout Acetaminophen And Hydrocodone Bitartrate - Acetaminophen: Hydrocodone Bitartrate 7.5-300 MG / 1 Tablet by mouth every 6 hours as needed for Pain
L89.616	Pressure-induced deep tissue damage of right heel	
I48.91	Unspecified atrial fibrillation	
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	
N18.30	Chronic kidney disease stage 3 unspecified	
I50.20	Unspecified systolic (congestive) heart failure	
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	
D50.9	Iron deficiency anemia unspecified	
I34.0	Nonrheumatic mitral (valve) insufficiency	
I05.0	Rheumatic mitral stenosis	
E78.5	Hyperlipidemia unspecified	
K21.9	Gastro-esophageal reflux disease without esophagitis	
E03.9	Hypothyroidism unspecified	
M10.9	Gout unspecified	
Z79.4	Long term (current) use of insulin	
Z79.01	Long term (current) use of anticoagulants	
Z86.19	Personal history of other infectious and parasitic diseases	

Prognosis fair	**Mental and Psychosocial Status** COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Endurance, Ambulation	**Activities Permitted** Exercises Prescribed, Up As Tolerated, Walker
DME & Supplies 4 wheeled walker, bath bench, diabetic supplies, walker, commode, wound care supplies	**Safety Measures** hand rails, bleeding precautions, ambulates with assistance, emergency phone # clearly displayed, smoke detectors , transfer with assist, supervision at all times, cardiac precautions, diabetic precautions, medication safety, ambulates with device, fall precautions, walker precautions, standard precautions, bathroom safety, activity supervision
Nutrition diabetic	**Allergies** NSAIDs!aspirin!NSAIDs aspirin, contrast dye

Advance Directives	Caregiver Status
Yes	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.	SN: family/caregiver will be responsible for managing treatment PT: patient will be responsible for managing treatment OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 2 (09/16/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 2 (09/27/26-10/03/26),WK4: 2 (10/04/26-10/10/26),WK5: 2 (10/11/26-10/17/26),WK6: 2 (10/18/26-10/24/26),WK7: 2 (10/25/26-10/31/26),WK8: 2 (11/01/26-11/07/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

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

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Yes

09/21/2026 Problems : #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Heel -
#2 - Open Wound - Anterior Right Foot -
#3 - Open Wound - Other - in between the 3rd, 4th, and 5th toes -
M1400 - Dyspnea

SN NARRATIVE

The patient is a 75 years old female with a past medical history of atrial fibrillation on warfarin therapy, chronic kidney disease stage 3, type 2 diabetes mellitus, PAD with chronic right foot/toe wounds, status post right hallux fixation, and recent cellulitis. The patient is alert and oriented x4. The right foot wound is being managed by a podiatrist with order to cleanse the right foot, in between the 3rd, 4th and5th toes and the heel with normal saline, apply betadine wet to dry dressing, secure with a kerlix, Change wounds x3 times a week M/W/F. The patient's daughter Lisa Cunningham is the primary caregiver. Wound care teaching was provided to Ms. Lisa and she verbalized understanding. Medication review was completed with the patient. INR was done and the result was 5.2. A message was left for the PCP with the INR result. Awaiting response. The patient has 3mg, 2mg, and 1mg tablets at home. She sleeps on the couch in the living room as she can't go up and down the stairs. She has a bedside commode in the living room. Teaching on foot elevation due to the right foot edema, medication compliance. She is diabetic but does not monitor her blood sugar as she does not have the machine. She ambulates with the walker.

Please reschedule OT evaluation for Monday. Evaluation attempted and missed secondary to patient being unable to give OT entry into the home. Patient states she is unable to ambulate tithe front door. Patient agreeable to Monday visit. Time:12:40pm- 12:51pm; travel time-23 mileage-13.

SN GOALS

PATIENT-STATED GOAL: For wound to heal

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

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

caregiver administers and/or packages medications appropriately

M2020 - Oral Med Management
abn cholesterol > 200 mg/dL
balance deficit
limited strength
muscle weakness
open sores/lesions
D0160 - Depression
limited endurance
M2102c - Med Admin
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: physician-ordered wound care: #3 - Open Wound - Other - in between the 3rd, 4th, and 5th toes -: Clean with normal saline, apply betadine soaked gauze, , cover with a dry dressing and secure with kerlix. Change dressing 3x weekly or PRN when soiled., physician-ordered wound care: #2 - Open Wound - Anterior Right Foot -: Clean with normal saline, apply betadine soaked gauze, , cover with a dry dressing and secure with kerlix. Change dressing 3x weekly or PRN when soiled., physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Heel -: Clean with normal saline, apply betadine soaked gauze, , cover with a dry dressing and secure with kerlix. Change dressing 3x weekly or PRN when soiled., cough/deep breathing exercises, teach/coordinate/arrange medication packaging and/or administration

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

OT CAREPLAN
OT frequency WK2: 1 (09/20/26-09/26/26),WK4: 1 (10/04/26-10/10/26),WK6: 1 (10/18/26-10/24/26),WK8: 1 (11/01/26-11/07/26)

09/22/2026 Problems : GG0170O1 - 12 Steps
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
M1400 - Dyspnea
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE triceps extensions, biceps curls 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE
75 yo female presenting to skilled OT services s/p hospitalization with sub acute rehabilitation secondary to dx of atherosclerosis of arteries rle with rle heel ulcer. Past medical history significant for atrial fibrillation, congestive heart failure, hyperlipidemia, heart failure, gastric reflux disease, peripheral vascular disease, diabetes, chronic kidney disease. Pt previously resided in 2 story home 10 steps to enter with single railing. Patient completed basic self care, functional transfer and functional ambulation independently. Patient's grandsons live with her. Someone rents basement. Patient currently presents with decreased standing balance, standing tolerance, bilateral UE strength and activity tolerance resulting in decreased self care, functional transfer and functional ambulation independence. Skilled OT services recommended at this time to address deficits hindering Patient from returning to prior level of functional independence.

OT GOALS
PATIENT-STATED GOAL: Get in the shower

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

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

PT CAREPLAN
PT frequency WK1: 1 (09/17/26-09/19/26)

PROCEDURES: Medication management : Review medication with pt, home exercise program: Seated knee extension, hip flexion, heelraises, toe raises, hip abduction, hamstring curls, hip extension amd progress to standing tes as tolerated 2-310 reps, dynamic standing balance exercises: Perform balance exercises to improve hip ankle and step strategies to reduce fall risk, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PT NARRATIVE
75 yo female referred to home health services following recent hospital and SAR stay with dx of atherosclerosis of arteries rle with rle heel ulcer. Past medical history significant for atrial fibrillation, congestive heart failure, hyperlipidemia, heart failure, gastric reflux disease, peripheral vascular disease, diabetes, chronic kidney disease. Pt lives in 2 story home 10 steps to enter with single railing.prior level of function pt reported she was wobbly when walking, had several falls negotiated steps I adls, currently uses bsc on main floor due to no bath main floor. pts grandsons live with her. Someone rents basement. Pt home is very dirty and cluttered there are extension cords lying across walkways creating high fall risk. Pt has a cat. Pt is pleasant and cooperative. Presents with impaired balance as evidenced by tinetti score of 10/28, tug of 26 seconds, negotiating up steps on hands and knees and down on buttocks moderate unsteadiness, moderate unsteadiness amb with rw at times standing outside rw, discontinuous step pattern wide BOS. Le weakness, and mild difficulty with transfers. Pt has good potential to benefit from skilled physical therapy to address above listed deficits.

PT GOALS
PATIENT-STATED GOAL: To improve my leg strength so I can get out and up and down the steps easier and and walk by myself

GOALS
Chair to Bed to Chair - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/10/2026

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Certifying Physician or Allowed Practitioner Name and Address **Jisha Varghese**
5601 Loch Raven Blvd
Baltimore, MD 21239
NPI 1881202570

Phone Number 4106614670

Fax Number 14106614671

Physician's Signature and Date Signed

X

Jisha Varghese, MD
09/10/2026: Date of physician last face-to-face