

Recert Package

NATIONAL EXCELLENCE HOME HEALTH CARE, INC.



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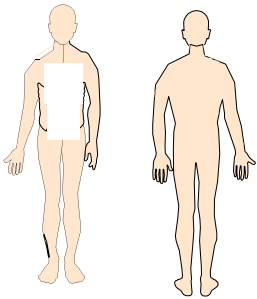
RECERTIFICATION ORDER-EVALUATION/AGREEMENT UPDATE

(Recert evaluation must be completed within 5 days before ending episode) (Certifying Physician Statement)

Patient Name _____ Med. Record _____
 SOC: _____ Recertification period: _____ to _____
 Primary Diagnosis _____ Onset Date _____
 Secondary diagnoses _____

What negative findings substantiate this Patient to be recertified? (Continuing Need for Services Statement) 

Wound/decubitus/ulcer orders:



Foley Yes No Size _____ FR _____ CC Change Q _____ Date last changed _____

Problem:

Mental Status: _____ Activity: _____

Functional limitations/homebound status: _____

Diet: _____ Need for Home Health Aide: _____

Who does patient live with? _____ Caregiver _____

Overwhelmed with _____ Patient's care _____ Household duties. Medical Supplies _____

Verbal order written during this certification: _____

Start Date	MEDICATION (changes, addition, deletions)	Dose	Route	Frequency	Duration	D/C Date

Services that need to continue (Frequency/Charges): Medicare payer, no charges expected Charges changes below

Agency regular charges explained in de Information Handbook

SN _____ PT _____

HHA _____ ST _____

MSW _____ OT _____

Discharge Plans _____

Physician Recertification Statement: I certify that in my estimation continued services will be required for _____ 

MD Name/ Phone _____ Last MD visit _____ Last MD contact by nurse/therapist _____

Patient/Representative Signature: _____ Date: _____

RN/Therapist Name/Signature/Title _____ Date _____

Physician Signature: _____ Date: _____

Original (Patient Chart)

Copy (Physician)

HOME HEALTH AIDE CARE PLAN (PLAN DE CUIDADO DE LA AYUDANTE DE ENFERMERA)

Patient Address: _____ Telephone No. _____

Directions to Home: _____

Care Manager: _____ Phone No. _____

Frequency/Duration: _____

Supervisory visits: ☐ every 14 days ☐ every 30 ☐ every 60 ☐ Other _____

Patient problem: _____

PARAMETERS TO NOTIFY CARE MANAGER / PARAMETROS A NOTIFICAR

T^o _____ BP _____

P _____ R _____

Urine _____

Other (pain) _____

DNR: ☐ Yes ☐ No

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply. Circle the appropriate item if separated by slash.

- | | | | |
|--|---|---|--|
| ☐ Lives alone/Vive solo
☐ Lives with other/Vive con otros
☐ Alone during the day/Solo durante el día
☐ Bed bound/Confinado a la cama
☐ Bed rest/BRPs/Descanso en la cama
☐ Up as tolerated/Se levanta hasta donde puede
☐ Amputee (specify)/Amputación: _____
☐ Partial weight bearing/Soporte de peso parcial: ☐ R ☐ L | ☐ Non weight bearing/No soporte de peso: ☐ R ☐ L
☐ Fall precautions/Prevención de caídas
☐ Special equipment/Equipos especiales: _____
☐ Speech/Communication deficit/Habla deficiente
☐ Vision deficit/Visión def: ☐ Glasses/Espejuelos
☐ Contacts/Lentes de contacto
☐ Other/Otro: _____
☐ Hearing deficit/Def. Auditiva: ☐ Hearing aid/Ayuda para oír | ☐ Dentures/Dentaduras: ☐ Upper/Sup. ☐ Lower/baja
☐ Partial/Parcial
☐ Oriented/Orientado x 3 ☐ Alert/Alerta
☐ Forgetful/Confused/Olvidadiso/Confuso
☐ Urinary catheter/Cateter urinario
☐ Prosthesis/Protesis (specify): _____
☐ Allergies/Alergias (specify): _____ | ☐ Diabetic/Diabético ☐ Do not cut nails/No cortar uñas
☐ Diet/Dieta: _____
☐ Seizure precaution/Precauciones con convulsiones
☐ Watch (observar por) for hyper/hypoglycemia
☐ Bleeding precautions/Prec. sangreamientos
☐ Prone to fractures/Posible fracturas
☐ Other (specify)/Otro (especificar): _____ |
|--|---|---|--|

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc as needed beside the appropriate item

ASSIGNMENT-TAREAS		Every visit	Weekly	Multi-Visits a day only				Other - Otro Comments/Instrucciones	ASSIGNMENT-TAREAS		Every visit	Weekly	Multi-Visits a day only				Other - Otro Comments/Instrucciones
				1	2	3	4						1	2	3	4	
VITALS / VITALES	Temperature/Temperatura	☐	☐	☐	☐	☐	☐		ACTIVITY / ACTIVIDADES	Assist with - Asistir con Ambulation/Ambulación	☐	☐	☐	☐	☐	☐	
	Pulse/Pulso	☐	☐	☐	☐	☐	☐			WIC/Walker/Cane - Silla Rueda/Andador/Bastón	☐	☐	☐	☐	☐	☐	
	Respirations/Respiración	☐	☐	☐	☐	☐	☐			Assist with Mobility/asistir con movilidad	☐	☐	☐	☐	☐	☐	
	Blood Pressure/Presión	☐	☐	☐	☐	☐	☐			Chair/Bed/Dangle-Silla/Cama/Oscilar	☐	☐	☐	☐	☐	☐	
	Weight/Peso	☐	☐	☐	☐	☐	☐			Commode/Cuña-Pato	☐	☐	☐	☐	☐	☐	
BATH / BAÑO	Pain Rating (0-10 scale)/Dolor	☐	☐	☐	☐	☐	☐		NUTRITION / NUTRICION	Shower/Tub=Ducha/Bañera	☐	☐	☐	☐	☐	☐	
	Tub/Shower-Bañera/Ducha	☐	☐	☐	☐	☐	☐			ROM Active/Passive-Rango de Mov. Activo/Pasivo	☐	☐	☐	☐	☐	☐	
	Bath: Bed/Sponge - Baño: Cama/Sponja	☐	☐	☐	☐	☐	☐			Arm R/L (Brazos D/I)	☐	☐	☐	☐	☐	☐	
	Partial/Complete-Parcial/Completo	☐	☐	☐	☐	☐	☐			Leg R/L (Pies D/I)	☐	☐	☐	☐	☐	☐	
HYGIENE / GROOMING / HIGIENE	Assist Bath-Chair - Asistir baño en silla	☐	☐	☐	☐	☐	☐		OTHER / OTRO	Positioning-Encourage / Cambio de Posiciones	☐	☐	☐	☐	☐	☐	
	Personal Care/Cuidado Personal	☐	☐	☐	☐	☐	☐			Assist/assistir _____ hrs	☐	☐	☐	☐	☐	☐	
	Assist with Dressing/Asistir vestirse	☐	☐	☐	☐	☐	☐			Exercise Per - Ejercicios por	☐	☐	☐	☐	☐	☐	
	Hair Care/Cuidado del cabello	☐	☐	☐	☐	☐	☐			PT / OT / SLP	☐	☐	☐	☐	☐	☐	
	Shampoo/Champú	☐	☐	☐	☐	☐	☐			Care Plan/Plan de cuidado	☐	☐	☐	☐	☐	☐	
	Skin Care/Cuidado de la piel	☐	☐	☐	☐	☐	☐			Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	
	Foot Care/Cuidado de los pies	☐	☐	☐	☐	☐	☐			Meal Preparation/Prep. de comida	☐	☐	☐	☐	☐	☐	
	Check Pressure Areas/Ulceras de presión	☐	☐	☐	☐	☐	☐			Assist with Feeding/Asistir alimentar	☐	☐	☐	☐	☐	☐	
	Nail Care/Cuidado de las uñas	☐	☐	☐	☐	☐	☐			Limit/Encourage-Limitar/Exigir	☐	☐	☐	☐	☐	☐	
	Oral Care/Cuidado oral	☐	☐	☐	☐	☐	☐			Fluid/Fluidoss	☐	☐	☐	☐	☐	☐	
PROCEDURES / PROCEDIMIENTOS	Clean Dentures/Limpiar dentaduras	☐	☐	☐	☐	☐	☐			Grocery Shopping/Comprar comida	☐	☐	☐	☐	☐	☐	
	Shave/Afeitar	☐	☐	☐	☐	☐	☐			Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	
	Other/Otro: _____	☐	☐	☐	☐	☐	☐			Wash Clothes/Lavar ropa	☐	☐	☐	☐	☐	☐	
	Assist with Elimination/Asistir eliminación	☐	☐	☐	☐	☐	☐			Light Housekeeping/Ligera limpieza	☐	☐	☐	☐	☐	☐	
	Catheter Care/Cuidado de catetes	☐	☐	☐	☐	☐	☐			Bedroom / Baño	☐	☐	☐	☐	☐	☐	
	Ostomy Care/Cuidar ostomía	☐	☐	☐	☐	☐	☐			Bathroom/Cuarto / Kitchen / Cocina	☐	☐	☐	☐	☐	☐	
	Record Intake/Output-Registro tomar/salida	☐	☐	☐	☐	☐	☐			Change Bed Linen/Cambiar sábanas	☐	☐	☐	☐	☐	☐	
	Inspect/ Reinforce/Inspeccionar	☐	☐	☐	☐	☐	☐			Equipment Care/Cuidado de equipos	☐	☐	☐	☐	☐	☐	
	Dressing/Vendas (see specifics in comment section/ver comentarios)	☐	☐	☐	☐	☐	☐			Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	
	Medication Reminder/Recordar medicinas	☐	☐	☐	☐	☐	☐										
Other (specify)/Otro (especificar):		☐	☐	☐	☐	☐	☐										

Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

SIGNATURE/TITLE _____ DATE _____ SIGNATURE/TITLE _____ DATE _____

PART 1 - Clinical Record

PART 2 - Patient Home Folder

PATIENT NAME - Last, First, Middle Initial _____ ID# _____

As Nurse Aide you are an important member of the home care team. It is important that you check your Aide Care Plan before initializing care. Perform only the tasks assigned on the patient's Care Plan. If there are tasks being performed that are not on the patient care plan, notify your supervisor for approval before the changes are made.

REMEMBER TO RESPECT PATIENT'S PRIVACY/PROPERTY

pnsystem.com

305.777.5580

(855)PNSystem

QUALITY ASSURANCE EVALUATION FORM

PATIENT / FAMILY QUESTIONNAIRE

DATE OF EVALUATION: _____

NAME OF STAFF RECORDING THE EVALUATION: _____

NAME OF PATIENT: _____

NAME OF PERSON MAKING RESPONSES: _____
(person being interviewed)

Rating from 1 "Disagree" - 5 "Strongly Agree"

QUESTIONS	ALWAYS/Good 4 - 5	SOMETIMES 2 - 3	NEVER 1
1. Did you like your nurse/aide/therapist?			
2. Was your nurse/aide/therapist always there when she was expected to be there?			
3. Did your nurse/aide/therapist always wear a clean uniform?			
4. Did your nurse/aide/therapist appear to know her job?			
5. Was your nurse/aide/therapist punctual?			
6. Would you say the nurse/aide/therapist took good care of you?			
7. Was your nurse/aide/therapist a good listener?			
8. Perception of effectiveness of Care Provided: Care Plan Management, Disease Management, Pain Management, Patient's Safety, Medication Management, Infection Prevention, Fall prevention.			
9. Your nurse/aide/therapist were always available to communicate with you?			
Other Comments			

Signature of Staff

Patient's Signature (optional)

CUESTIONARIO (Spanish version)

Fecha de la evaluación: _____

Nombre del empleado haciendo la encuesta: _____

Nombre del Paciente: _____

Nombre de la persona dando respuesta: _____
(Persona intervenida)

Escala desde 1 “No estoy de acuerdo” - 5 “Estoy completamente de acuerdo”

Preguntas	Siempre/Bien 4 - 5	Algunas Veces 2 - 3	Nunca 1
1. Le gusto el empleado (enfermera(o), ayudante, therapista?)			
2. Estuvo nuestro empleado siempre con usted cuando era esperado?			
3. Nuestros empleados siempre usaron uniformes limpios?			
4. Conocian nuestros empleados su trabajo?			
5. Nuestros empleados fueron puntuales?			
6. Diria que nuestros empleados le dieron un buen cuidado?			
7. Nuestros empleados oian sus opiniones?			
8. Evaluación del Cuidado recibido: Manejo del Plan de Cuidado, Manejo de la Enfermedad, Manejo del Dolor, Seguridad del Paciente, Manejo de los Medicamentos, Prevención de Infecciones, Prevención de Caídas.			
9. Nuestros empleados estuvieron siempre disponible para comunicarse con usted?			
Otros comentarios			

Firma de empleado

Firma del paciente (opcional)

QA AUDIT/REVIEW FORM

Patient Name/MR #: _____ Cert.Period: _____

Orders: **(All orders need date/time received)*

- ☐ **POC**(485) signed w/30 days, Initial VO (date/time)
- ☐ POC completed, frequency, orders correctly
- ☐ Reinstatement, Recert Order as applicable
- ☐ Intervention to identify hospit. and ER visits risks
- ☐ Therapy Care Plan (Short-Long term goals, modalities as tolerated, therapists professional expertise)
- Updates Plan (Aide Plan, reviewed q60d), Mod. Orders as need. Add Pt's goals, care pref.
- Medication re-conciliated (MD), interaction, **match** 485-Profile-Home folder
- Individualized plan, parameters to report MD, D/C planning, rehab potential
- Guidelines to involve family/caregivers in patient's care. Measurable (end-point) goals.
- ☐ Therapy Eval-Re-eval (before 30 days) (signed by MD if app.)
- Agreement Addendum in all Frequency changes (Mod.Orders, ROC, Recerts)
- Legal Representative communication, if applicable. Advance Directives info.

Notes:

- ☐ **Progress Notes** current in file, all disciplines
- ☐ POC followed (aide,PTA?) Reporting guideline to Agency, SV, MD office documented
- ☐ Vital Signs recorded
- ☐ Title, credentials in all notes
- ☐ Coordination of Care with other discipline reflected
- ☐ Medical supplies recorded
- ☐ Additional needs are identified during patient's care, MD notified, order obtained
- ☐ SV notes (Q14 days HHA with skill, Q60 days HHA without skill, Q30days LPN, PTA, OTA, STA)
- ☐ Handwashing
- ☐ Frequency of visit compliance (zero fraud tolerance)
- ☐ Therapy staff following POC, no modality used without order
- ☐ Infection Control, Universal Precautions stated in notes
- ☐ Diabetic, looking for help to adm. Injection
- ☐ Notes delivery on time to Agency (before Tuesday next week)
- ☐ Case Conference (Q30D)
- ☐ Team Comm.
- ☐ Glucometer Calibration (daily)/Quality Control weekly
- ☐ BS Log
- ☐ BP Log
- ☐ Non Verbal pain assessment (FLAC)
- ☐ Get Up and Go FallTest
- ☐ Norton/Branden Scale
- ☐ Procedure and Modalities, amount, freq, duration in therapy notes
- ☐ Weekly used, signed by Patient
- ☐ ALF: No staff signatures, copy of Patient Contract, ALF license
- ☐ Wound Forms, pictures, addendum weekly
- ☐ Depression Scale PHQ-9, if applicable
- ☐ Missed visit report (**Faxed to MD**)
- ☐ **Admission Package** Completed, 48 hrs
- ☐ Agreement completed, no blank spaces
- ☐ Education discussed with patient, Calendar
- ☐ Face to Face signed, 90 days before or within 30 days after SOC
- ☐ Nursing Bag procedure (CPR mask)
- ☐ Handwashing, glove/mask
- ☐ Advance Directive Information, Policy
- ☐ Bill of Rights according Accreditation
- ☐ Medication completed
- ☐ Initial/Admission Order
- ☐ If patient transfer to your Agency, from another, document Patient Elected transfer
- ☐ Pay Sources, Charge for services (*already in the handbook*), Frequency completed, **including in Home folder**.
- ☐ **OASIS** Assessment completed, 48 hrs
- ☐ Adult Assessment if applicable
- ☐ Pt Care Preferences, Personal ident.goals. Cgv Availability
- ☐ SOC OASIS, D/C OASIS for therapy services completed by an RN, need COMMUNICATION with therapy services
- ☐ D/C addendum for therapy completed by therapy services
- ☐ Transmission monthly(within 30D), encoding 7 days
- Transfer to In-patient Facility, **summary faxed to MD and Hospital(receiving facility)** Oxygen inst., contract(if applicable)
- ☐ **Performance Improvement** (PI Plan)
- ☐ Add Complaints/Grievance, Survey results (quarterly report) to PI discussion
- ☐ Document the issues, findings, threshold and corrective actions, how PI results improve Patient Quality Care
- ☐ Include all Incidents Report (Occurrence Report)
- ☐ Fall prevention, interventions
- ☐ Monitor Aide, therapy services
- ☐ OASIS Data, OBQI reports (Casper)
- ☐ Trends for improvement or replication
- ☐ **Discharge Packages**
- ☐ Notice of MC Provider Non Coverage (2 days before)
- ☐ D/C instruction
- ☐ ABN if applicable
- ☐ Therapy D/C addendum
- ☐ 60 Days Summary
- ☐ D/C summary if applicable
- ☐ Partial D/C if applicable
- ☐ (faxed to MD)
- ☐ (faxed to MD)

Comments:

Auditor Name/Title/Signature: _____ Date: _____



QUALITY ASSURANCE FORM PHYSICIAN QUESTIONNAIRE

Dear Dr. _____

We are conducting a survey on our Quality Assurance Standard. Please check the appropriate box in the questionnaire form below:

Thanks.

ITEMS PHYSICIAN	RESPONSE			
	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
1. Did agency staff display adequate knowledge and professionalism in maintaining patient records?				
2. Did agency staff make themselves accessible to physician when applicable?				
3. Were agency staff members able to communicate adequately with patient's family and to the physician?				
4. How would you rate overall quality of nursing care toward patients as performed by the staff of this agency?				
5. Other				

Date: _____

Physician's signature (optional if is by phone): _____

CLINICAL RECORDS: **SUMMARY REPORTS** - COMMUNICATION NOTE



HOME HEALTH CARE AGENCY (Reported to PAC)

NOTIFICATION OF CLIENT'S CLINICAL RECORD DEFICIENCIES

Client's Name: _____
Client's clinical record number: _____
Client's case manager: _____
Client's attending physician: _____
Client's principal diagnosis: _____
Client's admission date: _____
Client's discharge date: _____

Name of individual notified of client's clinical record deficiency(ies):

Client's clinical record deficiency(ies): (Action Plan if needed)

Signature of Individual who performed
Client's Clinical Record Discharge Analysis

Date of Signature

CLIENT SERVICE AGREEMENT ADDENDUM
MODIFICACION AL CONVENIO DE SERVICIO

Date/Fecha: _____

Patient: _____
(Paciente)

MR #: _____ SOC: _____

Certification period: _____ to _____

As part of your service/care, an adjustment to our agreement is necessary, please review the following addendum to our agreement and sign in the bottom as approval of the stated changes: *(Como parte de su servicio/cuidado nuestro acuerdo necesita ser modificado, por favor revise la modificación y firme abajo como prueba de su aprobación a los cambios)*

☐ Your physician made changes in your Plan of Care, as result the frequency of visit will be affected as follow: *(Su doctor ordenó cambios en su Plan de Cuidado, como consecuencia la frecuencia de visitas necesita ser modificada de la siguiente forma)*. **POC Copy received/Copia recibida.**

☐ The Patient's Medications were reviewed, updated as needed. *(Las medicinas del paciente se revizaron y actualizaron)*

☐ All involved discipline care plan reviewed. *(El Plan de cuidado de todas las disciplinas envueltas fue revizado)*

Discipline/Disiplina

Staff name/Title - Nombre New Frequency (Nueva frecuencia)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ Charge changes, explain: *(Cambio en los cargos, explicar)*

☐ N/A Emergency/Disaster reviewed, information changes Yes No
(if any change occurs, new Emergency Form must be completed)

Month/Mes:						
Sunday/Domingo	Monday/Lunes	Tuesday/Martes	Wednesday/Miérc.	Thursday/Jueves	Friday/Viernes	Saturday/Sábado
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐

☐ MD approved the changes *(Su doctor aprobó los cambios)*

☐ I accept the changes, and acknowledgement to receipt the Agreement addendum.

(Yo acepto los cambios y confirmo el recibo de los cambios al convenio)

☐ I participated/involved in the development of the Plan of Care

(Yo participé en el desarrollo del Plan de Cuidado)

☐ Other/Otro: _____

Month/Mes:						
Sunday/Domingo	Monday/Lunes	Tuesday/Martes	Wednesday/Miérc.	Thursday/Jueves	Friday/Viernes	Saturday/Sábado
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐

Patient/Representative Signature
Firma del paciente/representante

Date/Fecha

Agency's Representative
Representante de la Agencia

Date/Fecha

DRUG CLASSIFICATIONS

NOTE: CLASSIFICATIONS ARE NOT INCLUSIVE OF ALL SIDE EFFECTS - Reference: MOSBY'S

#	CLASS	SIDE EFFECTS
1	ANALGESICS / NARCOTIC	SEDATION / CONSTIPATION
2	ANALGESICS / NON-NARCOTIC	WELL TOLERATED
3	ANALGESICS / NSAIDS / ANTINFLAMMATORY	GI DISTRESS / DROWSINESS
4	ANTIBIOTICS	GI DISTRESS / ANAPHYLAXIS
5	ANTICOAGULANTS / ANTIPLATELETS	DIARRHEA / RASH / FEVER / BLEEDING
6	ANTICONVULSANTS	GI DISTRESS / ATAXIA / CONFUSION
7	ANTIDEMENTIA / CEREBRAL METABOLIC / ENHANCERS	GI DISTRESS / DIZZY / HA / INSOMNIA
8	ANTIDOTE	GI DISTRESS / TACHYCARDIA / HTN
9	ANTIFUNGAL	GI DISTRESS / HA / CHILLS
10	ANTIHYPERTENSIVES	GI DISTRESS / DIZZY / MUSCLE PAIN
11	ANTIMPOTENCE	HA / DIZZY / FLUSHING
12	ANTIMIGRAINE	DIZZY / TINGLING / SEDATION
13	ANTIPARASITIC	DIZZY / LOCAL IRRITATION
14	ANTITUBERCULAR	GI DISTRESS / RASH
15	ANTIVIRAL / ANTIRETROVIRAL	GI DISTRESS / HA / FUNGAL INFECTION
16	BLOOD / BLOOD DERIVATIVES	ANAPHYLAXIS / RASH / FEVER
17	BPH	DIZZY / HA
18	CANCER / CHEMOTHERAPEUTIC / ANTINEOPLASTICS	GI DISTRESS / BLOOD DYSCRASIA / ALOPECIA
19	CARDIAC / ANGINA / CAD / ASCVD	DIZZY / LOW BP / EDEMA / ΔK^+
20	CARDIAC / CHF / CARDIOMYOPATHY	DIZZY / LOW BP / EDEMA / ΔK^+
21	CARDIAC / DYSRHYTHMIA	LOW BP / LOW PULSE / EDEMA / ΔK^+
22	CARDIAC / HTN / ASHD	DIZZY / LOW PULSE / EDEMA / ΔK^+
23	CNS STIMULANT	INSOMNIA / NERVOUSNESS
24	CORTICOSTEROID ANTINFLAMMATORY	GI DISTRESS / EDEMA / ΔBS / EUPHORIA
25	DERMATOLOGICALS MISC	RASH / LOCAL IRRITATION / BURNING
26	DIABETES	LOW BS / ANAPHYLAXIS / HEPATOTOXICITY
27	DIETARY SUPPLEMENTS	GI DISTRESS / RASH
28	DIGESTANTS / GI ENZYMES	GI DISTRESS
29	DIURETICS	ELECTROLYTE DISTURBANCES / LOW BP
30	ELECTROLYTES	GI DISTRESS
31	GI / ANTIACIDS	CONSTIPATION / DIARRHEA / FLATULENCE
32	GI / ANTIDIARRHEAL / ANTISPASMODIC	CONSTIPATION / DRY MOUTH / URINARY RETENTION
33	GI / GASTRITIS / ULCER / REFLUX	GI DISTRESS / CONFUSION / HA
34	GI / LAXATIVES	GI DISTRESS / DEPENDENCE DIARRHEA
35	GI / NAUSEA / VOMITING	SEDATION / DRY MOUTH / BLURRED VISION
36	GLAUCOMA	HA / NAUSEA
37	GOUT / URICOSURIC	GI DISTRESS
38	HEMATINIC	GI DISTRESS / BLACK STOOLS
39	HEMATOPOIETIC	BONE PAIN / HTN
40	HEMOSTATIC	GI DISTRESS
41	HERBAL	GI DISTRESS / RASH
42	HORMONES	HOT FLASHES / BOATING / DEPRESSION
43	IMMUNOLOGIC / IMMUNOSUPPRESSANTS	HA / TREMORS / CANDIDA INFECTION
44	IV FLUSH	BURNING
45	MUSCLE RELAXERS	DROWSINESS / DRY MOUTH
46	OPHTHALMIC LUBRICANTS	REDNESS / IRRITATION
47	OSTEOPOROSIS	GI DISTRESS / LOCAL IRRITATION
48	OXYGEN	NASAL IRRITATION
49	PARKINSONS	LOW BP / DYSKINESIA / HALLUCINATIONS
50	PLASMA VOLUME EXPANDERS	EDEMA / ANAPHYLAXIS
51	PSYCHIATRIC / ANTIANXIETY / ANTIDEPRESSANTS	DIZZY / DROWSINESS / DRY MOUTH
52	PSYCHIATRIC / ANTIPSYCHOTICS / ANTIMANICS	EPS / DROWSINESS / DRY MOUTH
53	RESPIRATORY / ANTIHISTAMINES / DECONGESTANTS / ANTIALLERGY	DIZZY / DROWSINESS / DRY MOUTH
54	RESPIRATORY / ANTITUSSIVES / EXPECTORANTS	SEDATION
55	RESPIRATORY / BRONCHODILATORS	TACHYCARDIA / TREMORS / NERVOUSNESS / HA
56	SALICYLATES	GI DISTRESS / TINNITUS
57	SEDATIVES / HYPNOTICS	SEDATION / CONFUSION
58	THYROID	TACHYCARDIA / TREMORS / INSOMNIA
59	URINARY ANTISPASMODICS	LOW BP / URINARY RETENTION / DIZZY
60	VERTIGO / SYNCOPE	DRY MOUTH / DROWSINESS
61	VITAMINS / MINERALS	GI DISTRESS / ANAPHYLAXIS
62	OTHER	

NATIONAL EXCELLENCE HOME HEALTH CARE, INC.

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CHAP Hotline (*Línea de CHAP*)
1-800-656-9656 Monday-Friday
(*Lunes-Viernes*)

8:30 am to 5:00 pm

**At night, leave message about complaints
and/or questions about the Agency**

(*Por la noche, deje mensaje por quejas y/o
preguntas acerca de la Agencia*)

**After hours of operations, a message may be
left with our Answering Service.**

(*Después de horas de Oficina puede dejar un
mensaje con nuestro servicio de respuesta
telefónico.*)

