PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

Requested SOC date ______________* Complete form within 15 business days of the start of care date and submit to NC DMA.

Name ______________________________

Address ______________________________

Phone Number ______________________________

Medicaid ID # ______________________ Birthdate ______________________

Diagnosis ______________________________

____

Prognosis and expectations of specific disease process ______________________________

Date of last physician assessment ______________________________

Services requested & why ______________________________

Specify how many hours/days/weeks requested ______________________________

Informal caregivers' availability & training received ______________________________

Date of next MD appointment & name of MD ______________________________

TECHNOLOGY REQUIREMENTS & NURSING CARE NEEDS

Ventilator dependent? Circle one. NO YES Type ______________________________

Hours per day on ventilator ______________________________

Oxygen? Circle one. NO YES Actual liters per minute and hours per day required ______________________

Continuous prescribed rate? ______________ or adjusted daily or more often? [specify] ______________________

Maintain sats > ________ % Frequent need for adjustments and interventions? ______________________

Non-ventilator dependent tracheostomy? Circle one. NO YES

Actual frequency of suctioning and results ______________________________

Enteral (tube) feedings sole source of nutrition? Circle one. NO YES

Type of nutrition, frequency, method of receiving ______________________________

Licensed skilled nursing interventions and frequency ______________________________

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____

Medical history: note functional/communication limitations/incontinence ______________________________

____

____

Family & home dynamics that affect the licensed skilled nursing requirements ______________________________

____

What community-based resources have been utilized to assist this recipient? ______________________________

____

"I agree that the individual is medically stable except for acute episodes that Private Duty Nursing can manage in the home setting."

Print physician's name ______________________________

Print physician's address & phone number ______________________________

Physician's signature ______________________________

Date ______________________________