PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE OR INTERMEDIATE CARE FOR THE MENTALLY RETARDED

Section A – Identifying Information

1. Facility's Name and Address

County _____

2. Medicaid Number

3. Social Security Number

4. Sex | Age | 4A Birthdate

7. Patient's Name (Last, First, Middle Initial)

5. Type of Facility (Check One)
1. ☐ Nursing Facility
2. ☐ ICF/MR

6. Type of Recommendation
1. ☐ Initial
2. ☐ Level Change
3. ☐ Continued Placement

8. Date of Nursing Facility Admission / /

9. Patient Transferred from: (check one)
☐ Hospital ☐ Home ☐ Another Nurs. Home
☐ Private Pay ☐ Medicare

Member's Home Address _____
Member's Telephone Number _____

Date of Medicaid Application / /

9A. State Authority (MH & MR Screening)

Mother's Maiden Name:

Level I/II

This is to certify that the facility or attending physician is hereby authorized to provide the Dept. of Community Health, Division of Medical Assistance and the Dept. of Human Resources, Division of Family and Children Services with necessary information including medical data.

Restricted Auth. Code | Date

9B. This is not a re-admission for OBRA purposes

10. Signed _____ 11. Date _____
(Patient, Spouse, Parent, or other Relative or Legal Representative)

Restricted Auth. Code | Date

Section B – Physician's Examination Report and Recommendation

12. Diagnosis on Admission to Facility (Hospital Transfer Record May Be Attached)	1. ICD	2. ICD	3. ICD
1. Primary _____ 2. Secondary _____ 3. Other _____			

13. Treatment Plan (Attach copy of order sheet if more convenient)

Hospital Dates: _____ to _____

Hospital Diagnosis 1. Primary _____ 2. Secondary _____ 3. Other _____

Medications				Diagnostic and Treatment Procedures	
Name	Dosage	Route	Frequency	Type	Frequency

14. Recommendation Regarding Level of Care Considered Necessary
1. ☐ Skilled 2. ☐ Intermediate 3. ☐ Intermediate care for the Mentally Retarded

15. Length of Time Care Needed
1. ☐ Permanent 2. ☐ Temporary _____ Months estimated

16. Is Patient free of communicable diseases? 1. ☐ Yes 2. ☐ No

17. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

18. I certify that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded.

Physician's Signature

19. Physician's Name (Print)

Physician's Address (Print)

20. Date Signed By Physician / /

21. Physician's Licensure No.

Physician's Phone No. ( )

Section C – Evaluation of Nursing Care Needed (check appropriate box only)

22. Diet	23. Bowel	24. Overall Cond.	25. Restorative Pot.	26. Mental & Behavioral Status		
☐ Regular	☐ Continent	☐ Improving	☐ Good	☐ Agitated	☐ Noisy	☐ Dependent
☐ Diabetic	☐ Occas. Incontinent	☐ Stable	☐ Fair	☐ Confused	☐ Nonresponsive	☐ Independent
☐ Formula	☐ Incontinent	☐ Fluctuating	☐ Poor	☐ Cooperative	☐ Vacillating	☐ Anxious
☐ Low Sodium	☐ Colostomy	☐ Deteriorating	☐ Questionable	☐ Depressed	☐ Violent	☐ Well Adjusted
☐ Tube Feeding		☐ Critical	☐ None	☐ Forgetful	☐ Wanders	☐ Disoriented
☐ Other		☐ Terminal		☐ Alert	☐ Withdrawn	☐ Inappropriate Reaction

27. Decubitl	28. Bladder
☐ Yes ☐ Surgery	☐ Continent
☐ No Date	☐ Occas. Incontinent
☐ Infected	☐ Incontinent
☐ On Admission	☐ Catheter

29. Hours Out of Bed Per Day _____
☐ Intake ☐ IV
☐ Output ☐ Bedfast

☐ Catheter Care
☐ Colostomy Care
☐ Sterile Dressings
☐ Suctioning

30. Indicate Frequency Per Week

	Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel and Bladder Retrain	Activities Program
Received							
Needed							

31. Record Appropriate Legend

IMPAIRMENTS

1. Severe
2. Moderate
3. Mild
4. None

Sight ☐ Hear ☐ Speech ☐ Ltd. Motion ☐ Paralysis ☐

ACTIVITIES OF DAILY LIVING

1. Dependent
2. Needs Asst.
3. Independent
4. Not App.

Eats ☐ Wheel chair ☐ Transfers ☐ Bath ☐ Ambulation ☐ Dressing ☐

32. Remarks

33. Pre-Admission Certification Number

34. Signed

35. Date Signed / /

Do Not Write Below This Line

Continued Stay Review Date: _____

Payment Date _____ Approved For _____ Days Only!

36 Level of Care Recommended	LOS	37. Signature	Date	38. Attachments
			/ /	1. ☐ Yes 2. ☐ No

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