Type of Program: ☐ Nursing Facility ☐ GAPP ☒ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:
Name
address
DFCS County
address
Mailing Address

2. Medicaid Number: xxxxxxxxxxxx F

3. Social Security Number xxx-xx-xxxx

4. Sex: 8 | Age | 4A. Birthdate: 10-25-2002

5. Primary Care Physician: Xxxxxx Xxxxxxl, MD

6. Applicant's Telephone # xxx-xxx-xxxx

7. Does guardian think the applicant should be institutionalized? ☒ Yes ☐ No

8. Does child attend school? ☐ Yes ☒ No

9. Date of Medicaid Application / /

Name of Caregiver #1: Xxxxxx Xxxxx Name of Caregiver #2: Xxxxx Xxxxx

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: _____ 11. Date: _____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*
**See Attached

13. Diagnosis
**See Attached
1) Tay-Sachs Disease 2) Seizure Disorder 3) Chronic Lung Disease
(Add attachment for additional diagnoses)

1. ICD	2. ICD	3. ICD

14. Medications

Name	Dosage	Route	Frequency
**Refer to Attached Medication List			

15. Diagnostic and Treatment Procedures

Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)** **See Attached Treatment Plan
Previous Hospitalizations: 1/17/10 – For G-Tube Replacement – Plus 3 past admissions 11/17/04 – 11/27/04 Rehabilitative Services: Done by LPNs Other Health Services: _____
Hospital Diagnosis: 1) Tay-Sachs Disease 2) Secondary GI Bleed 3) Other Aspiration Pneumonia

17. Anticipated Dates of Hospitalization: N/A / /

18. Level of Care Recommended: ☐ Hospital ☒ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☒ Lives at home

21. Length of Time Care Needed _____ Months
1) ☒ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases?
☒ Yes ☐ No

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

24. Physician's Name (Print): Xxxxx Xxxxxx, MD
Physician's Address (Print): address

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital
_____ Physician's Signature

26. Date signed by Physician

27. Physician's Licensure No.

28. Physician's Telephone #: (xxx-xxx-xxxx

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

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular	☐ Age Dependent Incontinence	☒ Monitoring	☐ Prosthesis	☐ Agitated
☐ Diabetic Shots	☒ Incontinent - Age > 3 years	☐ CPAP/Bi-PAP)	☐ Splints	☐ Cooperative
☒ Formula-Special	☐ Colostomy	☐ CP Monitor	☒ Unable to ambulate > 18 months old	☐ Alert
☒ Tube feeding	☐ Continent	☒ Pulse Ox	☐ Wheel chair	☒ Developmental Delay
☒ N/G-tube/G-tube	☐ Other _____	☒ Vital signs > 2/days	☐ Normal	☒ Mental Retardation
☐ Slow Feeder		☒ Therapy		☐ Behavioral Problems (please describe, if checked)
☐ FTT or Premature		☒ Oxygen		☐ Suicidal
☐ Hyperal		☐ Home Vent		☐ Hostile
☐ IV Use		☐ Trach		
☒ Medications/GT Meds		☒ Nebulizer Tx		
		☒ Suctioning		
		☒ Chest - Physical Tx		
		☒ Room Air		

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care	☐ Dialysis in home	☐ Level I (5 or > surgeries)	Day care Services	☐ Deaf
☐ Sterile Dressings	☐ Ostomy	☒ Level II (< 5 surgeries)	☐ High Tech - 4 or more times per week	☒ Blind
☐ Decubiti	☒ Incontinent – Age > 3 years	☐ None	☒ Low Tech – 3 or less times per week or MD visits > 4 per month	☒ Seizures
☒ Bedridden	☐ Catheterization		☐ None	☒ Neurological Deficits
☐ Eczema-severe	☐ Continent			☒ Paralysis
☐ Normal				☐ Normal

39. Other Therapy Visits
☐ Five days per week ☒ Less than 5 days per week

40. Remarks **Height Approximately 41 inches, Weight 53 lbs**

41. Pre-Admission Certification Number

42. Date Signed

43. Print Name of MD or RN: Xxxxxx Xxxxxx MD
Signature of MD or RN: _____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date: _____ Admission Date _____ Approved for _____ Days or _____ Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No

46A. State Authority MH & MR Screening)
Level I/II
Restricted Auth. Code Date
46B. This is not a re-admission for OBRA purposes
Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor
☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date / /	52. Attachments (Contractor) ☐ Yes ☐ No	