Type of Program:

☐ Nursing Facility
☐ GAPP

【X TEFRA/Katic Beckett

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

Section A – Identifying Info	ormation											
Applicant's Name/Address:					2. Medicaid Number: 3. Social Security Number xxx-xxxxx							
Name				XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						irthdate		
address							F	8	-	10-25-20		
D	FCS County	5 Primar	v Care Physician									
address				Primary Care Physician     XXXXXX XXXXXXI, MD								
Mailing Addre	66		- [	6. Applicant's Telephone # XXX-XXX								
7. Does guardian think the app		itutionalized?		Does child attend school?     9. Date of Medicaid Application								
X Yes	s 🗆 No			□ Yes 🙀 No / /								
Name of Caregiver #1:	Xxxxxx Xxx	XX	Name	of Caregiv	er #2:	Xxxxx X	XxxxX					
I hereby authorize the physicia			der named h	herein to dis	close protected he							
the Department of Community authorization expires twelve (							es, for the purp	ose of Me	dicaid eligib	sility determin	ation. This	
authorization expires twerve (	2) montus from the	ance signed on w	nen revoke	su by me, w	inchever comes in	ISL.						
10. Signature:						11. Date:_						
Section B – Physician's Re	or other Legal Repr											
12. History: (attach additiona												
**See Attache	ed											
									1. ICD	2. ICD	3. ICD	
13. Diagnosis **See At		der	3) Chronic Lung Disease									
(Add attachment for add		Seizui	e Disore	ici	3)	ic bung i	Disease					
14.	Medications		77	15. Diagnostic and					d Treatment Procedures			
Name Dosage				Route Frequency				Type Frequency				
**Refer to Atta	ched	1.00										
Medication Li	st											
16. Treatment Plan (Attach e	opy of order sheet	if more conve	nient or o	ther perti	nent documents	)	****	ab a d m		4 D!		
- No. 100 -				-	us 3 past adn Done by		**See Atta			trian		
Previous Hospitalizations:	11/17/04 -	11/27/04th	abilitative S	Services:	Done by	LPNs	Other Health	Serviæs:				
Hospital Diagnosis: 1)	Tay-Sachs D	isease 2	) Secondar	y GI E	leed		3) Other A	spirati	on Pneu	monia	200	
17. Anticipated Dates of Hosp	italization: N/	A /	1	8. Level of	Care Recommend	ded: 🗆 H	ospital 🗆	Wursing !	Facility 🗆	IC/MR Facili	ty	
10. Type of Basemmendation	. 20 Porti	ent Transformed	from (obse	l- anal-	21 Langth	f Time Co	ra Naadad	Months	1 22	Le matiant fran	of.	
<ol> <li>Type of Recommendation</li> <li>□ Initial</li> </ol>	□ Hosp		other NF	k one):	21. Length (	ermanent		Months		communicable		
☐ Change Level of Ca	re Priva	te Pay 🗆 💢 v			2) 🗆 🖰	Temporary	estim	nated		Yes □ No		
23. This patient's condition		t ha managad hi	. 1	24 Physic	aian's Nama (Brin	et)-	Veren Ver	www M				
provision of Communi				24. Physician's Name (Print): Xxxxx Xxxxxx, MD								
					Physician's Address (Print): address							
<ol> <li>I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital</li> </ol>				26. Date signed by Physician 27. Physician's Licensure No. 28. Physician's Telephone #:  ( xkx-xxx-xxxx								
Physician's Signature												
Section C- Evaluation of N		ed (check app				1 22	14.170		1 22	D. 1	0	
29. Nutrition  Regular	30. Bowel		_	31. Cardiopulmonary Status			32. Mobility  □ Prosthesis			33. Behavioral Status  ☐ Agitated		
☐ Diabetic Shots	☐ Age Dependent Incontinence		Moni	P/Bi-PAP)		☐ Splints			☐ Cooperative			
Formula-Special	□XIncontinent - A	ge > 3 years	☐ CP N	fonitor		☐X Unable to ambulate >		te >	□ Alert			
■ Tube feeding ■ N/G-tube/G-tube	☐ Colostomy ☐ Continent		□X Pulse Ox     □X Vital signs > 2/days		ave	18 months old  ☐ Wheel chair			X Developmental Delay X Mental Retardation			
☐ Slow Feeder	Other		CX Thera		-,-	□ Normal			☐ Behavioral Problems			
☐ FTT or Premature			□ Oxygen						(please describe, if checked)			
☐ Hyperal ☐ IV Use				☐ Home Vent ☐ Trach								
■ Medications/GT				1					□ Suic	idal		
Meds			□X Nebu	lizer Tx					☐ Suic	idal		
Committee Commit			□X Nebu □XSucti	lizer Tx oning	Tx				☐ Suic	idal		
			□X Nebu □XSucti	llizer Tx oning t - Physical	Tx				□ Suic	idal tile		
34. Integument System	35. Urogenit		□X Nebu □XSucti □X Ches □X Roor 36.	lizer Tx oning t - Physical m Air Surgery			Therapy/Visits	i .	☐ Suic ☐ Hos	idal tile Veurological S	tatus	
☐ Burn Care	☐ Dialysis in hon		□X Nebu □XSucti □X Chess □X Room 36.	oning t - Physical m Air Surgery	urgeries)	Day car	re Services		☐ Suic ☐ Hos	idal tile Veurological S	tatus	
	☐ Dialysis in hon ☐ Ostomy	не	□X Nebu □XSucti □X Chess □X Room 36.	oning t - Physical m Air Surgery 11 (5 or > s 1 II (< 5 surgery	urgeries)	Day car	re Services h Tech - 4 or n		☐ Suic ☐ Hos	idal tile Veurological S f id	tatus	
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden	☐ Dialysis in hon ☐ Ostomy ☐XIncontinent – A ☐ Catheterization	ge > 3 years	□X Nebu □XSucti □X Chess □X Roor  36. □ Leve □X Leve	oning t - Physical m Air Surgery 11 (5 or > s 1 II (< 5 surgery	urgeries)	Day can High	re Services h Tech - 4 or n es per week r Tech - 3 or le	nore ess times	38. N Dea Dx Blin Dx Seiz Dx Neu	idal tile  leurological S f d nures rological Defi	1000	
□ Burn Care □ Sterile Dressings □ Decubiti □ Bedridden □ Eczema-severe	☐ Dialysis in hon ☐ Ostomy ☐XIncontinent – A	ge > 3 years	□X Nebu □XSucti □X Chess □X Roor  36. □ Leve □X Leve	oning t - Physical m Air Surgery 11 (5 or > s 1 II (< 5 surgery	urgeries)	Day can High time K Low	re Services h Tech - 4 or n es per week r Tech - 3 or le week or MD vi	nore ess times	38. N  Dea  Right Right Reserved Street	idal tile  Seurological S f id tures rological Defi	1000	
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden	☐ Dialysis in hon ☐ Ostomy ☐XIncontinent – A ☐ Catheterization	ge > 3 years	□X Nebu □XSucti □X Chess □X Roor  36. □ Leve □X Leve	oning t - Physical m Air Surgery 11 (5 or > s 1 II (< 5 surgery	urgeries)	Day can High time K Low	re Services h Tech - 4 or n es per week r Tech - 3 or le week or MD vi month	nore ess times	38. N Dea Dx Blin Dx Seiz Dx Neu	idal tile  Seurological S f id tures rological Defi	1000	
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