

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

Section A – Identifying Information		2. Medicaid Case Number		3. Social Security Number	
1. Facility's Name and Address County _____		9 Digits		2 Digits	
		_____		_____	
5. Type of Facility (Check One) 1. <input type="checkbox"/> Nursing Facility 2. <input type="checkbox"/> ICF/MR		6. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Level Change 3. <input type="checkbox"/> Continued Placement		4. Sex	
				Age	
		7. Patient's Name (Last, First, Middle Initial)		4.A Birthdate	
		8. Date of Nursing Facility Admission		9. Patient Transferred from: (check one) <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Another Nurs. Home <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicare	
Recipient's Home Address		Date of Medicaid Application		9A. State Authority (MH and MR Screening)	
Recipient's Telephone Number		/ /		/ /	
Mother's Maiden Name:		/ /		Level I/II	
This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Division of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including medical data.		Restricted Auth. Code		Date	
10. Signed _____ (Patient, Spouse, Parent, or other Relative or Legal Representative)		11. Date _____		9B. This is not a re-admission for OBRA purposes	
		/ /		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. 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. <input type="checkbox"/> Skilled 2. <input type="checkbox"/> Intermediate 3. <input type="checkbox"/> Intermediate care for the Mentally Retarded			15. Length of Time Care Needed 1. <input type="checkbox"/> Permanent 2. <input type="checkbox"/> Temporary _____ Months estimated		16. Is Patient free of communicable diseases? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
17. This patient's condition <input type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input type="checkbox"/> Community Care or <input type="checkbox"/> Home Health Services.			19. Physician's Name (Print)		
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 Address (Print)		
Physician's Signature _____			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.	
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other		<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy		<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal	
25. Restorative Pot.		26. Mental & Behavioral Status		27. Decubiti	
<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None		<input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert <input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction		<input type="checkbox"/> Yes <input type="checkbox"/> Surgery <input type="checkbox"/> No <input type="checkbox"/> Date _____ <input type="checkbox"/> Infected <input type="checkbox"/> On Admission	
28. Bladder		29. Hours Out of Bed		30. Indicate Frequency Per Week	
<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter		<input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning		Physical Therapy Occupational Therapy Remotive Therapy Reality Orientation Speech Therapy Bowel and Bladder Retrain Activities Program	
Per Day _____		<input type="checkbox"/> Intake <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Bedfast		Received _____ Needed _____	
31. Record Appropriate Legend					
1. Severe 2. Moderate 3. Mild 4. None		IMPAIRMENTS		ACTIVITES OF DAILY LIVING	
		Sight Hear Speech Ltd. Motion Paralysis		1. Dependent 2. Needs Asst. 3. Independent 4. Not App.	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Eats Wheel chair Transfers Bath Ambulation Dressing	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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 by G.M.C.F.:		LOS	37. Signature (G.M.C.F.)		Date
/ /		/ /	/ /		/ /
38. Attachments (G.M.C.F.)		1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No			