

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: DFCS County _____ Mailing Address _____		2. Medicaid Number:		3. Social Security Number					
		-----		4. Sex	Age	4A. Birthdate			
		5. Primary Care Physician							
		6. Applicant’s Telephone #							
7. Does guardian think the applicant should be institutionalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Does child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		9. Date of Medicaid Application / /					
Name of Caregiver #1: _____ Name of Caregiver #2: _____									
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: _____ <i>(Parent or other Legal Representative)</i>									
Section B – Physician’s Report and Recommendation									
12. History: <i>(attach additional sheet if needed)</i>									
				1. ICD	2. ICD	3. ICD			
13. Diagnosis 1) _____ 2) _____ 3) _____ <i>(Add attachment for additional diagnoses)</i>									
14. Medications				15. Diagnostic and Treatment Procedures					
Name		Dosage	Route	Frequency	Type	Frequency			
16. Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documents)									
Previous Hospitalizations: _____ Rehabilitative Services: _____ Other Health Services: _____									
Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____									
17. Anticipated Dates of Hospitalization: _____ / _____			18. Level of Care Recommended: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> IC/MR Facility						
19. Type of Recommendation: <input type="checkbox"/> Initial <input type="checkbox"/> Change Level of Care <input type="checkbox"/> Continued Placement		20. Patient Transferred from (check one): <input type="checkbox"/> Hospital <input type="checkbox"/> Another NF <input type="checkbox"/> Private Pay <input type="checkbox"/> Lives at home		21. Length of Time Care Needed _____ Months 1) <input type="checkbox"/> Permanent 2) <input type="checkbox"/> Temporary _____ estimated		22. Is patient free of communicable diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. 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			24. Physician’s Name (Print): _____						
			Physician’s Address (Print): _____						
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 #: ()		
Section C– Evaluation of Nursing Care Needed (check appropriate box only)									
29. Nutrition		30. Bowel		31. Cardiopulmonary Status		32. Mobility		33. Behavioral Status	
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic Shots <input type="checkbox"/> Formula-Special <input type="checkbox"/> Tube feeding <input type="checkbox"/> N/G-tube/G-tube <input type="checkbox"/> Slow Feeder <input type="checkbox"/> FTT or Premature <input type="checkbox"/> Hyperal <input type="checkbox"/> IV Use <input type="checkbox"/> Medications/GT Meds		<input type="checkbox"/> Age Dependent Incontinence <input type="checkbox"/> Incontinent - Age > 3 years <input type="checkbox"/> Colostomy <input type="checkbox"/> Continent <input type="checkbox"/> Other _____		<input type="checkbox"/> Monitoring <input type="checkbox"/> CPAP/Bi-PAP) <input type="checkbox"/> CP Monitor <input type="checkbox"/> Pulse Ox <input type="checkbox"/> Vital signs > 2/days <input type="checkbox"/> Therapy <input type="checkbox"/> Oxygen <input type="checkbox"/> Home Vent <input type="checkbox"/> Trach <input type="checkbox"/> Nebulizer Tx <input type="checkbox"/> Suctioning <input type="checkbox"/> Chest - Physical Tx <input type="checkbox"/> Room Air		<input type="checkbox"/> Prosthesis <input type="checkbox"/> Splints <input type="checkbox"/> Unable to ambulate > 18 months old <input type="checkbox"/> Wheel chair <input type="checkbox"/> Normal		<input type="checkbox"/> Agitated <input type="checkbox"/> Cooperative <input type="checkbox"/> Alert <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Behavioral Problems (please describe, if checked) <input type="checkbox"/> Suicidal <input type="checkbox"/> Hostile	
34. Integument System		35. Urogenital		36. Surgery		37. Therapy/Visits		38. Neurological Status	
<input type="checkbox"/> Burn Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Decubiti <input type="checkbox"/> Bedridden <input type="checkbox"/> Eczema-severe <input type="checkbox"/> Normal		<input type="checkbox"/> Dialysis in home <input type="checkbox"/> Ostomy <input type="checkbox"/> Incontinent – Age > 3 years <input type="checkbox"/> Catheterization <input type="checkbox"/> Continent		<input type="checkbox"/> Level 1 (5 or > surgeries) <input type="checkbox"/> Level II (< 5 surgeries) <input type="checkbox"/> None		Day care Services <input type="checkbox"/> High Tech - 4 or more times per week <input type="checkbox"/> Low Tech – 3 or less times per week or MD visits > 4 per month <input type="checkbox"/> None		<input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Seizures <input type="checkbox"/> Neurological Deficits <input type="checkbox"/> Paralysis <input type="checkbox"/> Normal	
39. Other Therapy Visits <input type="checkbox"/> Five days per week <input type="checkbox"/> Less than 5 days per week				40. Remarks					
41. Pre-Admission Certification Number				42. Date Signed		43. Print Name of MD or RN: _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					46A. State Authority MH & MR Screening)				
					Level I/II				
					Restricted Auth. Code		Date		
47. Hospitalization Precertification <input type="checkbox"/> Met <input type="checkbox"/> Not Met					46B. This is not a re-admission for OBRA purposes				
					Restricted Auth. Code		Date		
48. Level of Care Recommended by Contractor <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> IC/MR Facility									
49. Approval Period		50. Signature (Contractor) _____		51. Date / /		52. Attachments (Contractor) <input type="checkbox"/> Yes <input type="checkbox"/> No			