Physician's Referral Form for Home Extended Nursing Services

(This form must be completed and signed by the ordering physician and submitted by the home care agency with the prior authorization request.)

Requested Start of Care Date: _________________ **Primary Diagnosis:** ________________________________

Member Demographic Information			
Member Name:		Member ID #:	
Date of Birth:		Phone #:	
Address:			

Extended Nursing Services	
Approximate length of time services required:	___________ # of weeks/months (please specify)
Number of hours per week required:	
Date of last physician assessment:	
Date of next physician appointment:	
Caregivers available in the home:	Y / N
Relationship to member:	Days and times available:
Relationship to member:	Days and times available:

Technology Requirements and Nursing Care Needs							
Ventilator dependent:	Y/N	Type of ventilator:					
Hours per day on ventilator:		Oxygen:	Y/N	LPM:		Hours per day:	
O2 prescribed rate:		Or adjusted daily/more often:					
Maintain O2 saturations > _____ %		Frequency of adjustments and interventions:					
Non-ventilator dependent tracheostomy:	Y / N						
Frequency of suctioning and results:							
Enteral feedings:	Y / N	Sole source of nutrition:	Y / N	Frequency:			
Type of nutrition:		Method of receiving:					
Licensed skilled nursing interventions and frequency:							
Home infusion services:	Y / N	Type of therapy:		Vendor:			
Factors that impact the family members/caregivers ability to provide care:							
Community based resources currently utilized by member:							

"This individual requires the above medically necessary services at the duration and frequency indicated above."

Physician's Signature: ____ **Date:** __________________

(Electronic Signature Will *Not* Be Accepted)