DOH-4359 (2010)

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS *INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN*

1. Patient Identifying Information *(Use Additional Paper If Necessary)*

PATIENT NAME		CIN	DATE OF BIRTH	SEX
ADDRESS: APT/STREET	CITY		STATE	ZIP CODE
TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE

TO ABOVE ADDRESS? ☐ YES ☐NO IF NO EXPLAIN:_____

2. General Information

PHYSICIAN NAME		LICENSE #	TELEPHONE NO. ( )
ADDRESS: STREET	CITY	STATE	ZIP CODE

If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify:
Name _____ Profession: _____ License # _____

PLACE OF EXAMINATION: _____

DATE OF EXAMINATION: _____

3. Medical Findings

NOTE: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

Height: _____ Weight: _____

For the condition(s) requiring personal care:

Primary Diagnosis _____ ICD-9-CM Code _____

Secondary Diagnosis _____ ICD-9-CM Code _____

Describe the patient's current medical/physical condition _____

Is the patient's condition stable? ☐ Yes ☐ No

Is the patient appropriate for Hospice care? ☐ Yes ☐ No

Describe the current treatment plan and therapeutic goals including the prognosis for recovery: _____

Describe any prohibited activities or functional limitations: _____

Is the patient self-directing? ☐ Yes ☐ No

Is the patient able to summon help by any means? ☐ Yes ☐ No

If no, explain _____

Is the patient able to ambulate independently? ☐ Yes ☐ No With devices? ☐ Yes ☐ No Other Assistance? ☐ Yes ☐ No

Describe: _____

Is the patient continent of bowel? ☐ Yes ☐ No of bladder? ☐ Yes ☐ No

Catheter/Colostomy Needs: _____

List all current medications (prescription and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):

Can the patient self-administer medications: ☐ Yes ☐ No

If the patient requires a modified diet or has other special nutritional or dietary needs, describe: _____

Please indicate any task, treatments or therapies currently received, or required by the patient: _____

Does the patient require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)?

☐ Yes ☐ No

If Yes, please indicate:

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Contributing Factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patient's ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME. I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION. NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PARTS 515, 516, 517 AND 518 OF TITLE 18 NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM, PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES WHEN MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature _____ Date _____

PLEASE SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

New York State Department of Health