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

Section A – Identifying Information

1. Facility's Name and Address

County _____

2. Medicaid Case Number — 9 Digits | 2 Digits

3. Social Security Number

4. Sex | Age | 4.A Birthdate

If case No. has S or P in this Block enter

7. Patient's Name (Last, First, Middle Initial)

5. Type of Facility (Check One)
1. ☐ Nursing Facility
2. ☐ ICF/MR

6. Type of Recommendation
1. ☐ Initial
2. ☐ Level Change
3. ☐ Continued Placement

8. Date of Nursing Facility Admission

9. Patient Transferred from: (check one)
☐ Hospital ☐ Home ☐ Another Nurs. Home
☐ Private Pay ☐ Medicare

Recipient's Home Address _____
Recipient's Telephone Number _____

Date of Medicaid Application

9A. State Authority (MH and MR Screening)

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

9B. This is not a re-admission for OBRA purposes

10. Signed _____ (Patient, Spouse, Parent, or other Relative or Legal Representative) 11. Date _____

Restricted Auth. Code | Date

Section B – Physician's Examination Report and Recommendation

1. ICD | 2. ICD | 3. ICD

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

Name	Dosage	Route	Frequency

Diagnostic and Treatment Procedures

Type	Frequency

14. Recommendation Regarding Level of Care Considered Necessary
1. ☐ Skilled 2. ☐ Intermediate 3. ☐ Intermediate care for the Mentally Retarded

15. Length of Time Care Needed
1. ☐ Permanent 2. ☐ Temporary _____ Months estimated

16. Is Patient free of communicable diseases? 1. ☐ Yes 2. ☐ No

17. This patient's condition ☐could ☐could not be managed by provision of ☐Community Care or ☐Home Health Services.

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 Signature

19. Physician's Name (Print)

Physician's Address (Print)

20. Date Signed By Physician

21. Physician's Licensure No.

Physician's Phone No. ( )

Section C – Evaluation of Nursing Care Needed (check appropropriate box only)

22. Diet
☐ Regular
☐ Diabetic
☐ Formula
☐ Low Sodium
☐ Tube Feeding
☐ Other

23. Bowel
☐ Continent
☐ Occas. Incontinent
☐ Incontinent
☐ Colostomy

24. Overall Cond.
☐ Improving
☐ Stable
☐ Fluctuating
☐ Deteriorating
☐ Critical
☐ Terminal

25. Restorative Pot.
☐ Good
☐ Fair
☐ Poor
☐ Questionable
☐ None

26. Mental & Behavioral Status
☐ Agitated ☐ Noisy ☐ Dependent
☐ Confused ☐ Nonresponsive ☐ Independent
☐ Cooperative ☐ Vacillating ☐ Anxious
☐ Depressed ☐ Violent ☐ Well Adjusted
☐ Forgetful ☐ Wanders ☐ Disoriented
☐ Alert ☐ Withdrawn ☐ Inappropriate Reaction

27. Decubiti
☐ Yes ☐ Surgery
☐ No Date
☐ Infected
☐ On Admission

28. Bladder
☐ Continent
☐ Occas. Incontinent
☐ Incontinent
☐ Catheter

30. Indicate Frequency Per Week

	Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel and Bladder Retrain	Activities Program
Received							
Needed							

29. Hours Out of Bed Per Day _____
☐ Intake ☐ IV
☐ Output ☐ Bedfast

☐ Catheter Care
☐ Colostomy Care
☐ Sterile Dressings
☐ Suctioning

31. Record Appropriate Legend
1. Severe
2. Moderate
3. Mild
4. None

IMPAIRMENTS: Sight ☐ Hear ☐ Speech ☐ Ltd. Motion ☐ Paralysis ☐

1. Dependent
2. Needs Asst.
3. Independent
4. Not App.

ACTIVITES OF DAILY LIVING: Eats ☐ Wheel chair ☐ Transfers ☐ Bath ☐ Ambulation ☐ Dressing ☐

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. ☐ Yes 2. ☐ No

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