Recipient's Name	Medicaid ID Number

PHYSICIAN'S ORDER FOR PDHC

The Louisiana Pediatric Day Health Care Program (PDHC) is a Medicaid covered service for a medically fragile recipient from birth up to 21 years of age. It is not intended to be respite care. Pediatric Day Health Care Program (LAC 50:XV.Chapters 275-281)

Parent/Guardian:	Phone number	☐ Recipient is medically stable

DOB:	Sex:	Provider Name and Phone Number:

Current Diagnoses	ICD-10	Secondary Diagnoses	ICD-10	Surgical Procedures	CPT

I certify/recertify that I am the attending physician for this pediatric patient. I authorize these PDHC services and will periodically review the plan. In my professional opinion, the services listed on this PDHC ORDER AND PLAN OF CARE are medically necessary and appropriate in amount, duration, and scope due to the recipient's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held every four months between recipient and physician.

PHYSICIAN'S SIGNATURE **DATE** **NPI NUMBER**

PDHC PLAN OF CARE

To Be Developed by PDHC Registered Nurse With Physician Collaboration Prior to Placement in the Facility

PDHC PROVIDER NAME	PDHC PROVIDER NUMBER	Start of Care Date	Certification Period
			From _____ To _____

FUNCTIONAL LIMITATIONS

☐ Ambulation ☐ Amputation ☐ Cognitive ☐ Contracture
☐ Developmental Disabilities(fine, gross, oral-motor/speech language)
☐ Endurance ☐ Hearing ☐ Paralysis ☐ Speech
☐ Totally Dependent ☐ Partially Dependent ☐ Vision
☐ Other

REHABILITATION POTENTIAL

☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor
☐ None ☐ Uncertain

MENTAL STATUS

☐ Alert ☐ Oriented ☐ Agitated/Irritable ☐ Lethargic/Non-responsive
☐ Infant ☐ Toddler ☐ Pre-School ☐ School

PATIENT ACTIVITY

☐ Sedentary(Bed, Stander, Adaptive Devices) ☐ Reposition/Turn Freq: _____ ☐ As Tolerated ☐ Unrestricted ☐ Other _____
☐ Within functional limitations/developmental level

PRECAUTIONS

☐ Universal ☐ Seizure ☐ Reflux ☐ Respiratory ☐ Child Safety ☐ Aspiration ☐ FX precautions ☐ Other _____

TRANSPORTATION ☐ PDHC Center / Contractor ☐ Family

PRESCRIBED SERVICES **ALLERGIES:**

MEDICATIONS	DOSE	FREQUENCY	ROUTE	MEDICATIONS	DOSE	FREQUENCY	ROUTE

☐

Recipient's Name	Medicaid ID Number

Other Special Orders/Instructions:

Diagnostic/Laboratory Studies:

Change CVL cap after blood draws and PRN

INFUSION THERAPY

☐ TPN ☐ Drugs_____ ☐ Fluids_____ Total Volume(ml./hr.______) Freq._____ Duration: _____ Rate:_____ Total Volume(ml./hr.______ ☐ Other_____
Route: ☐ PIV ☐ PICC ☐ Central Line type: _____ ☐ Mediport IV Site _____ ☐ Change Freq: ______ ☐ Sterile Dressing change q: _____
☐ Infusion Pump

AIRWAY MANAGEMENT

☐ Oxygen @ _____ Route _____ ☐ Continuous ☐ PRN ☐ Maintain O2 sats at > _____% ☐ Oxygen via NC/mask/ambu-bag up to _____/lpm in an emergency situation ☐ Humidity: Type: ☐Air ☐Thermovent ☐Other	☐ Pulse Oximetry Freq: _____ High Heart:_____ Low Heart:_____ High SAT:_____ Low SAT:_____ Settings: (_____) high limit (_____) low limit with a (_____) sec delay ☐ PassyMuir Valve Freq:_____ Duration:_____ ☐ as tolerated ☐ while under direct observation ☐ Spot checks q _____ ☐ Cardiac/Respiratory monitor – Freq: _____ Duration: _____	☐ Trach Size/Type _____Trach care q _____ ☐ Soap and water ☐ ½ st H202 ☐ Other _____ Change trach q _____ Change trach ties q_____ ☐ Suction q_____ Catheter Size: _____ ☐ Bulb suction nares and oral/nasal-pharynx ☐ PRN ☐ CPT q _____ ☐ PRN ☐ Manual ☐Vibrator ☐Vest

☐ Ventilator Type: _____
Mode: ☐ SIMV: BackUp Rate/Rate:_____ Pressure Control:_____ Pressure Support:_____ Volume Control:_____ ☐ PIP ☐ PEEP Rate: _____
☐ BIPAP: INS Pressure:_____ Exp Pressure: _____ BIPAP ST: _____ Backup Rate:_____
☐ CPAP:_____ (Pressure) Settings:____________________ ☐ Alarm limits: High _____Low _____ ☐ Assist control
☐ Oxygen _____FiO2/LPM ☐ Alarm limits: High _____Low _____ ☐ Heater Temp _____degrees ☐HME ☐ Other _____

NUTRITION / DIET ☐ NPO ☐ PO ☐ ENTERAL

Formula Type/Cal:	**Mixing Directions:** ☐ Age Appropriate Diet _____
_____/_____	☐ Amount _____ ☐ Route _____ ☐ Frequency _____ ☐ Other _____ ☐ Feeding Pump ☐ Rate_____

☐ **FEEDING TUBE CARE**
☐ NGtube ☐ Gtube ☐ Jtube Type: _____ Size: _______ _____ cm lengths
☐ Feeding Tube Care as needed ☐ Daily ☐ PRN
☐ Flush q _____ with _____ Amount _____
☐ Change or replace feeding tube q _____ ☐ PRN
☐ May replace dislodged G-Tube with Foley catheter or replacement _____ G -Tube.
☐ Prior to 3 months post op GI must be contacted and referred to MD/ER
☐ Site assessment Frequency _____
☐ Other _____

☐ Weight q _____ ☐ Height q _____ ☐ Fax or call weights to MD q _____ ☐ Head circumference q _____
☐ Chest circumference q _____ ☐ ABD Circumference q _____ ☐ Other
☐ BS/urine checks and SN > 3/d

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☐ **OSTOMY CARE**

Type: _____
☐ Change q _____
☐ Irrigate q _____ with _____
☐ Other _____

☐ **NEUROLOGICAL CARE**

☐ Monitor seizure activity and LOC
☐ Maintain seizure log
☐ Notify MD of prolonged or increased seizure activity

☐ **CATHER CARE**

☐ Cath. Type _____ ☐ Site _____
☐ Frequency q _____ Type: _____

☐ **MISC. CARE**

☐ Skin ☐ Oral ☐ Perineal ☐ ENT ☐ Wound
☐ Cast ☐ ADL's ☐ Other _____

GENERAL CARE

☐ Nurse to complete daily head-to-toe assessment.
☐ TPR daily and prn ☐ Daily I&O ☐ BP q _____ and prn with parameters of _____ ☐ Capillary refill daily and prn
☐ Daily Hygiene Requirements
☐ Nurses to do daily follow-up of developmental therapies/goals including but not limited to ROM and in accordance with therapists plan of care.
☐ Daily medication administration – monitor effects
☐ Nurse to assess family/caregiver knowledge & compliance with recipient's care needs and provide education/reinforcement of skills as indicated.
☐ In an emergency may transport via EMS to ER, center nurse to accompany recipient on vehicle
☐ Other

EQUIPMENT/SUPPLIES

☐ Oxygen/Tubing	☐ Nasal Cannula	☐ Trach	☐ Trach Ties	☐ Trach Collar	☐ Humidivents
☐ Vent/Circuits	☐ Compressor	☐ Humidifier	☐ Concentrator	☐ Fisher Paykel	☐ Ambu-bag
☐ Suction machine	☐ Suction catheters	☐ Pulse Oximeter	☐ Pulse-ox Probes	☐ A/B Monitor	☐ Belts/Leads-A/B monitor
☐ Nebulizer machine	☐ Nebulizer kits	☐ Feeding Pump	☐ Feeding Bags	☐ Feeding Tubes	☐ Protective Equipment
☐ Glasses	☐ Hearing- aides	☐ Hand-splints/DAFO/AFO's		☐ CPT vests	☐ Prosthesis ☐ Other

THERAPEUTIC SERVICES

☐ PT : Freq. _____ ☐ OT : Freq. _____ ☐ ST : Freq. _____ ☐ Developmental Stimulation ☐ Visual Therapy
☐ Hearing Therapy ☐ Special Education ☐ Other _____

Hospitalizations (within last 6 months):

Current Medical Condition:
Prognosis:

Risk Factors associated with Medical Diagnoses:

Goals:

For Recertification only: Accomplishments toward goals; Assessment of effectiveness of services; Acknowledgment of annual face to face evaluation between recipient and physician.

FREQUENCY/DURATION OF PDHC Services: _____Days/Week _____Hours/Day (partial or full) _____Duration

Discharge Plans

I certify this plan of care is individualized to address the recipient's problems, goals, and required services and to ensure the recipient's developmental needs are addressed. This plan of care addresses specific goals for care and contains specific criteria for transitioning from or discontinuing participation in pediatric day health care with the facility.

Parent/Guardian	PDHC Representative	Prescribing Physician
Date	Date	Date