Division of Health Care Financing and Policy
Home and Community Based
State Plan Services

PHYSICIAN EVALUATION For Adult Day Health Care Services

Note to Physician: This form provides assistance in determining medical necessity for the ADHC service and documentation of the health and social needs of the patient.

Patient Name: _____ Medicaid ID: _____
Date of Birth: _____ Age: _____ Date of Examination: _____
Physician's Name: _____
Physician's address: _____
City, State, Zip Code: _____Phone:_____

Vital Signs: _____

Tuberculosis Screening:

2-Step TB Skin Test: □ Yes Date 1st Test:_____Results: _____
Date 2nd Test: _____ Results: _____
□ No To be given by ADHC within 24 hours of admission per NAC 441A.380(2b).

Chest X-Ray (Only if patient has documented history of Positive skin test): □ Yes Date:_____ □ No
Results: _____

Does this patient have any infectious diseases? □ Yes □ No

Specify: _____

Diagnoses:
1. _____
2. _____
3. _____

Is patient taking any medications that will be given during the times the individual will be attending the program (include any over the counter medications)? □ Yes □ No

Name of Medications	Route / Dosage / Frequency

Cognitive impairments or limitations at time of exam: □ None □ Memory Impairment □ Social
□ Psychological □ Behavior

Physical Impairments or limitations at time of exam: □ None □ Assist w/ambulation □ Has Prosthesis
□ Assist with transfers □ Has assistive device (cane, walker, wheelchair/scooter) □ Visual Impairment

Nutritional Status: □ Excellent □ Good □ Fair □ Poor

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Nutritional Needs/Special Diet: □ None
1._____
2._____

Allergies: □ No □ Food □ Medication

What: _____

History/Physical:
_____
_____
_____

Based on today's exam and review of health history, the following services are ordered: (Please mark all that apply)

□ Nursing Services
□ Care Coordination
□ Medical supervision
□ Meals (not full regimen)
□ Other (please describe) _____
□ Nutritional Assessment and Planning
□ Recipient training in activities of daily living
□ Social and recreational activities
□ Restorative therapy (speech, physical or occupational) and care

This person is appropriate for Adult Day Health Care Services (ADHC): □Yes □No

Why does this patient need ADHC services/Additional Orders?_____
_____
_____
_____

What are the recommended hours/days per week?

□ 6 hours/day or more □ less than 6 hours/day

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday □ Sunday

Physicians Signature: _____ Date: _____

I, _____herby authorize my physician
(Applicant's name)

_____ to complete this form and
(Physician's name)

release necessary medical information to the QIO-like vendor in order to verify program eligibility.

_____
SIGNATURE OF APPLICANT Date