Beneficiary's Name	Medicaid ID Number

PHYSICIAN'S ORDER FOR PDHC

The Louisiana Pediatric Day Health Care Program (PDHC) is a Medicaid covered service for medically fragile beneficiaries 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	☐ Beneficiary 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 beneficiary'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 90 days between the beneficiary and prescribing 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

Beneficiary'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 ☐R ate_____

☐ **FEEDING TUBE CARE**
☐ NG tube ☐ G tube ☐ J tube 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

Beneficiary's Name	Medicaid ID Number

☐ **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 beneficiary's care needs and provide education/reinforcement of skills as indicated.
☐ In an emergency situation, if a beneficiary is transported via ambulance to ED, the PDHC center nurse to accompany beneficiary in 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 beneficiary 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 beneficiary's problems, goals, and required services and to ensure the beneficiary'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**