Westchester gov.com

Department of Social Services
Medical/Home Care Services

For internal use only
Nurse: PHN Arbelo-Velazquez, R.
☐ **F.Y.I.**
☐ **6 Weeks Assessment**
☐ **New Case (A.S.A.P.)**

Physician Name: Dr.	
Address:	
Telephone #:	
Fax #:	E-mail:

Date:
Caseworker: PC Addison, D. Supervisor: PC Byrnes, R.
Telephone #: 914-995-6482
Right **Fax #**: Nurses J Artale (914) 813-4333 Weston-Azim (914) 813-4331 Sweet & Byrnes (914) 813-4330

MEDICAL RECOMMENDATION FOR HOME CARE

We have received a request for home care for your patient. If you concur, It is required by N.Y.S. Dep't. of Health that this form be filled in as completely as possible. If services are not required, so indicate on this form. In either instance, please sign, date, and return this form in the enclosed envelope. **Please Note : The completion of this medical form, with any and all recommendations, must reflect a medical examination within the last 30 days.**

CLIENT INFORMATION

Patient Name:	**D. O. B.:**	**SEX:**
Address:	**Telephone # :**	
	CIN #:	
Responsible Other:	**Relationship:**	**Tel #:**

HOSPITAL / SNF INFORMATION (if applicable)

Time of Adm: Time of Disch:

Hospital / SNF Name :_____ Adm. Date :_____ Disch. Date :_____.
Reason for Admission :_____.
Social Worker / Discharge Planner :_____ Tel. # :_____.
Physician Coordinating Hospital / SNF Care :_____ Tel. # :_____.
Patient's Community Physician (s/p Discharge) :_____ Tel. # :_____.
Does Patient Live Alone ? ☐ **Yes** ☐ **No**. If no, with whom does patient reside ?_____.

MEDICAL STATUS

PRIMARY DIAGNOSIS (ES) **ICD-10 Code#:**_____.
SECONDARY DIAGNOSIS (ES) **ICD-10 Code#:**_____.
PROGNOSIS (SHORT TERM/LONG TERM) :_____.

Is the patient's condition stable? ☐ **Yes** ☐ **No**
Is the patient self-directing? ☐ **Yes** ☐ **No**
Is the patient appropriate for Hospice care? ☐ **Yes** ☐ **No**
Patient's height _____ and weight_____
Describe any prohibited activities or functional limitations_____

MEDICAL NEEDS

Special Diet?_____.
_____.
Allergies?_____.
_____.
Other?_____.
_____.
Can patient administer medications independently? ☐ **Yes** ☐ **No**
Does patient need reminders to take medications? ☐ **Yes** ☐ **No**
Does patient need supervision in taking medications? ☐ **Yes** ☐ **No**
Does patient need help with preparation of medications? ☐ **Yes** ☐ **No**

MEDICATIONS

Name	Dose	Freq.	Route

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

Has a referral been made to a Certified Home Health Agency (CHHA) for any skilled nursing services? Please describe and indicate agency (ies) which are involved._____.

AMBULATION / TRANSFER NEEDS

	CAN	CANNOT	CAN WITH ASSISTANCE OF: CANE	WALKER	PERSON	OTHER
Ambulate Inside						
Ambulate Outside						
Arise From Seated Position						
Arise From Bed						
Transfer To W/C						

Does patient experience any problems with incontinence and/or does patient require assistance with toileting? Please explain : _____.

MENTAL STATUS

Can patient appropriately direct his/her own activities? ☐ Yes ☐ No Can patient respond to direction from others? ☐ Yes ☐ No

Please mark (X) the following, as appropriate:

	SOMETIMES	ALWAYS		SOMETIMES	ALWAYS
Disorientation			Short-term Memory Deficit		
Agitation			Impaired Judgment		
Wandering			Mood Disorder / Psychosis		
Communication Problems			Aggression		

Please elaborate on any mental health/behavioral items above marked (X) _____.

_____.

Do you recommend Home Care Services for this patient? ☐ Yes ☐ No

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: _____

Is this patient capable of utilizing a PERS? ☐ Yes ☐ No. Does this patient need/require a PERS (an electronic communication system which enables a patient to summon help in the event of an emergency)? ☐ Yes ☐ No.

MEDICAL TRANSPORTATION NEEDS IN THE COMMUNITY: PUBLIC ( ) TAXI ( ) AMBULETTE ( ) Ambulette Stretcher Mode ( ) AMBULANCE ( )

When using a taxi, is an escort required for patient to get to medical appointments? ☐ Yes ☐ No

Date of Patient's Last Examination (within 30 days) : _____.

ADDITIONAL COMMENTS (if necessary) : _____.

PHYSICIAN NAME (PRINT) : _____ LIC.# : _____.

NY MEDICAID PROVIDER # (MMIS.#) : _____.

National Provider Identifier (NPI) #: _____

PHYSICIAN SIGNATURE : _____ DATE : _____.

ADDRESS : _____ TELEPHONE # : _____.

_____ FAX # : _____.

If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify:

Name _____ Profession: _____ License # _____

PLACE OF EXAMINATION: _____

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

Patient: _____

Form # 1050 (10/22/19)

THIS FORM MUST BE SIGNED BY A PHYSICIAN