

PHYSICIAN'S ORDER FOR PDHC

The Louisiana Pediatric Day Health Care Program (PDHC) is a Medicaid covered service for a medically fragile child provided when a parent or guardian is not available to provide appropriate care due to employment, attending school, or having a medical/mental condition that would prevent the parent or guardian from providing care for the child. It is not intended to be respite care. Pediatric Day Health Care Program (LAC 50:XV.Chapters 275-281)

CHILD'S NAME			Recipient Medicaid ID Number		
Parent/Guardian:		Phone number		<input type="checkbox"/> Child is medically stable	
DOB:	Sex:	Provider Name and Phone Number:			
<u>Current Diagnoses</u>	ICD 9	Secondary Diagnoses	ICD-9	Surgical Procedures	ICD-9

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 Child'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 each year 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 <input type="checkbox"/> Ambulation <input type="checkbox"/> Amputation <input type="checkbox"/> Cognitive <input type="checkbox"/> Contracture <input type="checkbox"/> Developmental Disabilities(fine, gross, oral-motor/speech language) <input type="checkbox"/> Endurance <input type="checkbox"/> Hearing <input type="checkbox"/> Paralysis <input type="checkbox"/> Speech <input type="checkbox"/> Totally Dependent <input type="checkbox"/> Partially Dependent <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	REHABILITATION POTENTIAL <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> None <input type="checkbox"/> Uncertain MENTAL STATUS <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Agitated/Irritable <input type="checkbox"/> Lethargic/Non-responsive <input type="checkbox"/> Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Pre-School <input type="checkbox"/> School						
PATIENT ACTIVITY <input type="checkbox"/> Sedentary(Bed, Stander, Adaptive Devices) <input type="checkbox"/> Reposition/Turn Freq: _____ <input type="checkbox"/> As Tolerated <input type="checkbox"/> Unrestricted <input type="checkbox"/> Other _____ <input type="checkbox"/> Within functional limitations/developmental level							
PRECAUTIONS <input type="checkbox"/> Universal <input type="checkbox"/> Seizure <input type="checkbox"/> Reflux <input type="checkbox"/> Respiratory <input type="checkbox"/> Child Safety <input type="checkbox"/> Aspiration <input type="checkbox"/> FX precautions <input type="checkbox"/> Other _____							
TRANSPORTATION <input type="checkbox"/> PDHC Center / Contractor <input type="checkbox"/> Family							
PRESCRIBED SERVICES ALLERGIES:							
MEDICATIONS	Dose	Frequency	Route	Medications	Dose	Frequency	Route

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

<input type="checkbox"/> Oxygen @ _____ Route _____ <input type="checkbox"/> Continuous <input type="checkbox"/> PRN <input type="checkbox"/> Maintain O2 sats at > _____ % <input type="checkbox"/> Oxygen via NC/mask/ambu-bag up to _____ /lpm in an emergency situation <input type="checkbox"/> Humidity: Type: <input type="checkbox"/> Air <input type="checkbox"/> Thermovent <input type="checkbox"/> Other	<input type="checkbox"/> Pulse Oximetry Freq: _____ High Heart: _____ Low Heart: _____ High SAT: _____ Low SAT: _____ Settings: (____) high limit (____) low limit with a (____) sec delay <input type="checkbox"/> PassyMuir Valve Freq: _____ Duration: _____ <input type="checkbox"/> as tolerated <input type="checkbox"/> while under direct observation <input type="checkbox"/> Spot checks q _____ <input type="checkbox"/> Cardiac/Respiratory monitor – Freq: _____ Duration: _____	<input type="checkbox"/> Trach Size/Type _____ Trach care q _____ <input type="checkbox"/> Soap and water <input type="checkbox"/> ½ st H2O2 <input type="checkbox"/> Other _____ Change trach q _____ Change trach ties q _____ <input type="checkbox"/> Suction q _____ Catheter Size: _____ <input type="checkbox"/> Bulb suction nares and oral/nasal-pharynx <input type="checkbox"/> PRN <input type="checkbox"/> CPT q _____ <input type="checkbox"/> PRN <input type="checkbox"/> Manual <input type="checkbox"/> Vibrator <input type="checkbox"/> 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: <input type="checkbox"/> Age Appropriate Diet _____ <input type="checkbox"/> Amount _____ <input type="checkbox"/> Route _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Feeding Pump <input type="checkbox"/> 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

<input type="checkbox"/> Ostomy Care Type: _____ <input type="checkbox"/> Change q _____ <input type="checkbox"/> Irrigate q _____ with _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Neurological Care <input type="checkbox"/> Monitor seizure activity and LOC <input type="checkbox"/> Maintain seizure log <input type="checkbox"/> Notify MD of prolonged or increased seizure activity
--	--

<input type="checkbox"/> Catheter Care <input type="checkbox"/> Cath. Type _____ <input type="checkbox"/> Site _____ <input type="checkbox"/> Frequency q _____ Type: _____	<input type="checkbox"/> Misc. Care <input type="checkbox"/> Skin <input type="checkbox"/> Oral <input type="checkbox"/> Perineal <input type="checkbox"/> ENT <input type="checkbox"/> Wound <input type="checkbox"/> Cast <input type="checkbox"/> ADL's <input type="checkbox"/> 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 child's care needs and provide education/reinforcement of skills as indicated.
 In an emergency may transport via EMS to ER, center nurse to accompany child on vehicle
 Other _____

EQUIPMENT/SUPPLIES

<input type="checkbox"/> Oxygen/Tubing	<input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> Trach	<input type="checkbox"/> Trach Ties	<input type="checkbox"/> Trach Collar	<input type="checkbox"/> Humidivents
<input type="checkbox"/> Vent/Circuits	<input type="checkbox"/> Compressor	<input type="checkbox"/> Humidifier	<input type="checkbox"/> Concentrator	<input type="checkbox"/> Fisher Paykel	<input type="checkbox"/> Ambu-bag
<input type="checkbox"/> Suction machine	<input type="checkbox"/> Suction catheters	<input type="checkbox"/> Pulse Oximeter	<input type="checkbox"/> Pulse-ox Probes	<input type="checkbox"/> A/B Monitor	<input type="checkbox"/> Belts/Leads-A/B monitor
<input type="checkbox"/> Nebulizer machine	<input type="checkbox"/> Nebulizer kits	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Feeding Bags	<input type="checkbox"/> Feeding Tubes	<input type="checkbox"/> Protective Equipment
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing- aides	<input type="checkbox"/> Hand-splints/DAFO/AFO's	<input type="checkbox"/> CPT vests	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> 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 child's problems, goals, and required services and to ensure the child'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