# 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)

<table>
<thead>
<tr>
<th>Parent/Guardian:</th>
<th>Phone number</th>
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<tbody>
<tr>
<td>DOB:</td>
<td>Sex:</td>
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<table>
<thead>
<tr>
<th>Current Diagnoses</th>
<th>ICD-10</th>
<th>Secondary Diagnoses</th>
<th>ICD-10</th>
<th>Surgical Procedures</th>
<th>CPT</th>
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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.

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# PDHC PLAN OF CARE

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

<table>
<thead>
<tr>
<th>PDHC PROVIDER NAME</th>
<th>PDHC PROVIDER NUMBER</th>
<th>Start of Care Date</th>
<th>Certification Period From</th>
<th>To</th>
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</table>

**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, Stand, 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**

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>ROUTE</th>
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</table>

**ALLERGIES**

<table>
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</table>
Other Special Orders/Instructions:

Diagnostic/Laboratory Studies:

Change CVL cap after blood draws and PRN

**INFUSION THERAPY**

<table>
<thead>
<tr>
<th>TPN</th>
<th>Drugs</th>
<th>Fluids</th>
<th>Total Volume (ml/hr.)</th>
<th>Freq.</th>
<th>Duration</th>
<th>Rate</th>
<th>Total Volume (ml/hr.)</th>
</tr>
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Route:  
- PIV
- PICC
- Central Line type:   
- Mediport
- IV Site
- Change Freq:  
- Sterile Dressing

**AIRWAY MANAGEMENT**

<table>
<thead>
<tr>
<th>Oxygen @ ___</th>
<th>Route ___</th>
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</thead>
<tbody>
<tr>
<td>Continuous</td>
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</tr>
<tr>
<td>Maintain O2 sats at &gt; ___%</td>
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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:  

**VENTILATOR**

- Type:  
- Mode:   
- SIMV:  
- BackUp 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  
do degrees  
HME  
Other  

**NUTRITION / DIET**

- NPO  
- PO  
- ENTERAL

**FEEDING TUBE CARE**

- NGtube  
- Gtube  
- Jtube  
- Type:  
- Size:  
- cm lengths

Feeding Tube Care as needed
- Daily  
- PRN

Flush q  
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

Page 2 of 3
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

CATHETER 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
- 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