**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)

Parent/Guardian: [35x469]

DOB: [35x508] Sex: [35x511] Provider Name and Phone Number: [35x514]

Current Diagnoses | ICD-10 | Secondary Diagnoses | ICD-10 | Surgical Procedures | CPT |
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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 90 days between the recipient and prescribing physician.

**PHYSICIAN’S SIGNATURE**

**DATE**

**NPI NUMBER**

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**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**
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**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:**

<table>
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<tr>
<th>MEDICATIONS</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>ROUTE</th>
<th>MEDICATIONS</th>
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[ ]
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 sat @ %
- [ ] Oxygen via NC/mask/ambu-bag up to /lpm in an emergency situation
- [ ] Humidity:
  - [ ] 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
- [ ] 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

### NUTRITION / DIET

- [ ] NPO
- [ ] PO
- [ ] ENTERAL

- [ ] Age Appropriate Diet

- [ ] Formula Type/Cal:
  - [ ] /

- [ ] Mixing Directions:
  - [ ] Amount
  - [ ] Route
  - [ ] Frequency
  - [ ] Other
  - [ ] Feeding Pump
  - [ ] 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

- [ ] 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
  - **Freq:** [ ]
  - **Duration:** [ ]

- [ ] 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
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.

<table>
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<tr>
<th>Parent/Guardian</th>
<th>PDHC Representative</th>
<th>Prescribing Physician</th>
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<tr>
<td>Date</td>
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Recipient’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

- **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
- Daily medication administration – monitor effects
- Nurse to do daily follow-up of developmental therapies/goals including but not limited to ROM and in accordance with therapists plan of care.
- 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
- 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 recipient and physician.

FREQUENCY/DURATION OF PDHC Services: _____ Days/Week _____ Hours/Day (partial or full) _____ Duration

Discharge Plans