## Division of Health Care Financing and Policy Home and Community Based State Plan Services

## PHYSICIAN EVALUATION For Adult Day Health Care Services

**Note to Physician**: This form provides assistance in determining medical necessity for the ADHC service and documentation of the health and social needs of the patient.

Patient Name:	Medicaid ID:								
Date of Birth:		Age:	 Date of Exam	nination:					
Physician's Name:									
Physician's address:									
City, State, Zip Code:	:Phone:								
Vital Signs:									
Tuberculosis Screening	j.								
2-Step TB Skin Test:	□ Yes I	Date 1 <sup>st</sup> Test:	Res	ults:					
						2 441A.380(2b).			
Chest X-Ray (Only if I Results:		•		st):    Yes	Date:	□ No			
Does this patient have	any infectious dise	ases? □ Yes	□ No						
Specify:									
Diagnoses:									
3.									
T	1' '' '1 ' '1	11 ' 1				/: 1 1			
Is patient taking any many over the counter m			ing the times the □ No	e individual wil	be attending th	ie program (include			
any over the counter in	. $\Box$	103	L 110						
Name of Medications			Route / Dosage / Frequency						
Cognitive impairments	or limitations at ti	me of exam:	□ Non	e □ Mem	ory Impairment	□ Social			
□ Psychological	□ Behav	ior							
Physical Impairments of	or limitations at tim	ne of exam:	□ None	□ Assist w/aı	nbulation	□ Has Prosthesis			
□ Assist with transfers	□ Has as	sistive device	(cane, walker, w	heelchair/scoot	er) 🗆 Vi	sual Impairment			
Nutritional Status:	□ Excellent	□ Good	d □ Fair	□ Poo	or				

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Nutritional Needs/Special Di		□ None						
1					-			
<u>Allergies:</u> □ No	□ Food	□ Medication						
What:					_			
<u>History/Physical</u> :					_			
				ered: (Please mark all that app	- - ply)			
□ Nursing Services	□ N	Nutritional Assessment and	d Planning					
Care Coordination   Recipient training in activities of daily living								
<ul><li>Medical supervision</li><li>Meals (not full regimen)</li></ul>	<ul> <li>□ Social and recreational activities</li> <li>n) □ Restorative therapy (speech, physical or occupational) and care</li> </ul>							
				cupationar) and care				
What are the recommended	a nours/days pei	: week?						
□ 6 hours/day or more	□ less than 6	hours/day						
□ Monday □ Tuesday	□ Wednesday	y 🗆 Thursday	□ Friday	□ Saturday □ Sunday				
Physicians Signature:			Da	ite:				
I,			herby	authorize my physician				
	(Applicant's na	ime)						
	(Physician's na		to	complete this form and				
	•				ļ			
release necessary medical in	formation to the (	QIO-like vendor in order t	o verify program	ı eligibility.				
SIGNATURE OF APPLICA	NT		Date					

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