**Physician Order Form for Rehabilitation Care and Personal Care for Private Non-Medical Institution Medical Eligibility Sec 97 Appendix E**

Client Name: Date of Birth:

Needs the level of care and services outlined in the area below, to ensure the client’s mental health or rehabilitation in those areas improves and/or remains stable.

Diagnosis ICD 10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following services are to be provided and are medically necessary for Rehabilitation Level of Care**

* Assistance with establishing or regaining functional skills.
* Assistance with self-understanding, crisis prevention and self-management.
* Assistance with socialization and leisure skill development.
* Assistance with development and enhancement of social roles (IE: community and treatment facility).
* Assistance with activities connected with the rehabilitation goals and objectives identified in the client’s plan of care.
* Supervision or assistance with administration of physician ordered medication(s).
* Personal supervision or being aware of residents’ general whereabouts.
* Observing / monitoring the resident while on the premises to ensure their health and safety.
* Reminding/ prompting/ coaching the resident to carry out activities of daily living.
* Arranging transportation or providing transportation to meet treatment needs.
* Assisting client or making phone calls for appointments recommended by medical providers or as indicated in the client's plan of care.
* Reporting changes in behavior: Observing and monitoring resident's behavior and reporting changes in the resident's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate.

Physician Name: (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*Note: complete pg 2 which identifies medical care needs \*\*\*\*

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**Identify the following services that are medically necessary for personal care / health care (check ones that apply)**

Identify what assistance or supervision of activities of daily living as needed:

Bathing Dressing Eating Toileting

Personal Hygiene Activities

Performance of incidental household tasks essential to the activities of daily living and to the maintenance of resident health and safety.

Identify what assistance or supervision in managing medical care needs: Please identify if client has any of the following:

Oxygen Nebulizer CPAP/BIPAP Mechanical Diet

Specialized diet

Other durable equipment ordered by a physician (example: geriatric/hospital bed, catheter)

Does the client need assistance in managing Diabetes: Yes No

Sliding scale insulin assistance in completing blood sugars

Continuous Glucose monitoring device

Does client have mobility issues and requires a 1st floor bedroom or one floor living? Yes No

Does client have an assistive device for locomotion: Yes No

Cane walker wheelchair

Does client have visual or hearing impairments that require assistive devices or consideration in placement. Yes No

 Hearing Visual Please explain:

Physician Name: (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_