□ Nursing Facility□ GAPP□ TEFRA/Katie Beckett Type of Program:

## PEDIATRIC DMA 6(A) PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

	formation								
Applicant's Name/Address			2. Medi	caid Number:		3. Social	Security Nun	nber	
11									
						4. Sex	Age	4A. Birthdate	
DFCS County				5. Primary Care Physician					
				6. Applicant's Telephone #					
Mailing Address									
7. Does guardian think the ap		tutionalized?		8. Does child attend school?  Solution  9. Date of Medicaid Application					
L Te	s 🗆 No			☐ Yes ☐ No / /					
Name of Caregiver #1:			Name of Careg			_			
I hereby authorize the physicia the Department of Community	an, facility or other hea	alth care provid	ler named herein to d	lisclose protected he	ealth information and rele	ase the medi	cal records of	the applicant/beneficiary to	
authorization expires twelve (						ose of Medic	caid engionity	y determination. This	
10.00					1.5.				
10. Signature:									
Section B – Physician's Report and Recommendation									
12. History: (attach additional	al sheet if needed)								
						1.	ICD 2	2. ICD 3. ICD	
13. Diagnosis 1)	2)			3)					
(Add attachment for add									
14. Medications				15. Diagnostic and Treatment Procedures					
Name Dosage		Route	Route Frequency		Type Frequency				
16. Treatment Plan (Attach o	copy of order sheet i	if more conve	enient or other per	tinent documents	)				
Previous Hospitalizations:			_			G			
Previous Hospitalizations:		Kena	abilitative Services:_		Other Healtr	1 Services:			
Hospital Diagnosis: 1)			) Secondary		3) Other				
17. Anticipated Dates of Hosp	oitalization:	/	18. Level	of Care Recommen	ded: ☐ Hospital ☐	Nursing Fa	cility   IC	MR Facility	
19. Type of Recommendation	20. Patie	nt Transferred	from (check one):	21. Length	of Time Care Needed	Months	22. Is p	patient free of	
☐ Initial	☐ Hospi		other NF	1)	Permanent			nmunicable diseases?	
☐ Change Level of Ca ☐ Continued Placeme		e Pay   Liv	es at home	2) 🗆	Γemporary estir	nated	☐ Ye	s 🗆 No	
23. This patient's condition	□ could □ could not			sician's Name (Prir	t):		I		
provision of □ Community Care or □ Home Health Services □				Physician's Address (Print):					
25. I certify that this patient re	e signed by Physic		: N.	20 D	hysision's Tolonhone #				
by a nursing facility, IC/MR facility, or hospital ( )								hysician's Telephone #:	
by a nursing facility, IC/W		icion's Cianota			Tan 27. Thysician s I	licensure ino			
	Phys	ician's Signatu d (check appi	ıre		Tan 27. Thysician ST	Licensure INO			
Section C– Evaluation of N 29. Nutrition	Phys		ıre		32. Mobility	Licensure No	(		
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