Westchester gov.com

Department of Social Services
Medical/Home Care Services

For internal use only
Nurse:
☐ **F.Y.I.**
☐ **6 Weeks Assessment**
☐ **New Case (A.S.A.P.)**

Physician Name: Dr.	
Address:	
Telephone #:	
Fax #:	E-mail:

Date:
Caseworker: Supervisor:
Telephone #:
RightFax #: Creacy & Weston-Azim 813-4331 Varbaro 813-4330 Nurses 813-4333

MEDICAL RECOMMENDATION FOR PERSONAL CARE SERVICES

We have received a request for personal care services for your patient. If you concur, It is required by N.Y.S. Dep't. of Health that this form be filled in as completely as possible. If services are not required, so indicate on this form. In either instance, please sign, date, and return this form in the enclosed envelope. **Please Note : The completion of this medical form, with any and all recommendations, must reflect a medical examination within the last 30 days.**

CLIENT INFORMATION

Patient Name:	**D. O. B.**:	**SEX**:
Address:	**Telephone # :**	
	CIN #:	
Responsible Other:	**Relationship**:	**Tel #**:

HOSPITAL / SNF INFORMATION (if applicable)

Hospital / SNF Name :_____Adm. Date :_____Disch. Date :_____.
Reason for Admission :_____.
Social Worker / Discharge Planner :_____Tel. # :_____.
Physician Coordinating Hospital / SNF Care :_____Tel. # :_____.
Patient's Community Physician (s/p Discharge) :_____Tel. # :_____.
Does Patient Live Alone ?_____YES_____NO. If no, with whom does patient reside ?_____.

MEDICAL STATUS

PRIMARY DIAGNOSIS (ES) **ICD-10 Code#**_____.
SECONDARY DIAGNOSIS (ES) **ICD-10 Code#**_____.
PROGNOSIS (SHORT TERM/LONG TERM) :_____.

MEDICAL NEEDS

Special Diet?_____.
_____.
Allergies?_____.
_____.
Other?_____.
_____.
Can patient administer medications independently?_____YES_____NO.
Does patient need reminders to take medications?_____YES_____NO.
Does patient need supervision in taking medications?_____YES_____NO.
Does patient need help with preparation of medications?_____YES_____NO.

MEDICATIONS

Name	Dose	Freq.	Route

Has a referral been made to a Certified Home Health Agency (CHHA) for any skilled nursing services? Please describe and indicate agency (ies) which are involved._____.
_____.
_____.

AMBULATION / TRANSFER NEEDS

	CAN	CANNOT	CAN WITH ASSISTANCE OF : CANE	WALKER	PERSON	OTHER
Ambulate Inside						
Ambulate Outside						
Arise From Seated Position						
Arise From Bed						
Transfer To W/C						

Does patient experience any problems with incontinence and/or does patient require assistance with toileting? Please explain : _____.
_____.

MENTAL STATUS

Can patient appropriately direct his/her own activities?_____YES_____NO
Can patient respond to direction from others? _____YES_____NO

Please mark (X) the following, as appropriate:

	SOMETIMES	ALWAYS		SOMETIMES	ALWAYS
Disorientation			Short-term Memory Deficit		
Agitation			Impaired Judgment		
Wandering			Mood Disorder / Psychosis		
Communication Problems			Aggression		

Please elaborate on any mental health/behavioral items above marked (X) _____.
_____.
_____.

Do you recommend Personal Care Services in the home for this patient?_____YES_____NO

Is this patient capable of utilizing a PERS?_____YES_____NO. Does this patient need/require a PERS (an electronic communication system which enables a patient to summon help in the event of an emergency)?_____YES_____NO.

MEDICAL TRANSPORTATION NEEDS IN THE COMMUNITY : **PUBLIC ( ) TAXI ( ) AMBULETTE ( )**
Ambulette Stretcher Mode ( ) AMBULANCE ( )
When using a taxi, is an escort required for patient to get to medical appointments?_____YES_____NO

Date of Patient's Last Examination **(within 30 days) : _____.**

ADDITIONAL COMMENTS (if necessary) :_____.
_____.
_____.
_____.

PHYSICIAN NAME (PRINT) :_____ LIC.# :_____.
NY MEDICAID PROVIDER # (MMIS.#) :_____.
National Provider Identifier (NPI) #:_____

PHYSICIAN SIGNATURE :_____DATE :_____.

ADDRESS :_____TELEPHONE # :_____.
_____.
_____.FAX # :_____.

Patient: _____

Form # 1050 (10/27/15) **THIS FORM MUST BE SIGNED BY A PHYSICIAN**