North Carolina Division of Medical Assistance
Community Alternatives Program for Children
PHYSICIAN'S REQUEST FORM FOR IN-HOME NURSING SERVICES

Name ____ Medicaid ID#_____________________________________

Address ____

Telephone Number __________________________________ Date of Birth _____________________________________

Diagnoses ____
____

Prognosis and expectations of specific disease process ____
____

Date last seen_________ ____

TECHNOLOGY REQUIREMENTS AND CARE NEEDS

1. Ventilator
☐ NO ☐ YES, type ______________________________ and hours per day __________________________

2. Tracheostomy
☐ NO ☐ YES, actual frequency of suctioning including PRN use _____________________________________

3. Oxygen
☐ NO ☐ YES, continuous stable rate
☐ YES, continuous, rate adjusted daily/ more often
☐ YES, PRN for_______________________; the actual frequency of PRN use is_________________

4. Other Needs for a Nurse
____
____
____
____

5A. Family/home dynamics influencing in-home care
____
____

5B. Caregiver availability
____
____

5C. Caregiver competency with in-home care
____
____

6. What other resources have been used to assist this child/family?
____
____

MD Name ______________________________________ Name of Practice ___________________________
MD Signature ___________________________________ Date_____________________________________

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