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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-03182 (06/2023) |  **STATE OF WISCONSIN** Wis. Admin. Code § DHS 105.17 and 107.112 |
| PHYSICIAN PRESCRIPTION – PLAN OF CAREClient Status Based on *In Home RN* Assessment |
| PERSONAL CARE SERVICES |
| Start of Care Date*(Start care only after physician signs)*      | Certification Period*(OFFICE fill in dates received from MA prior authorization)*From:       To:       | Medical Record No.      | Agency Cert No.      | Payor Source      |
| Date of Birth      | Sex [ ]  M [ ]  F | Medications (include dose, frequency, reason; include oxygen and liter flow):**(THIS PERSONAL CARE AGENCY DOES NOT MANAGE MEDICATIONS)**      |
| Allergies      |
|  | Principal Diagnosis      | Date      |
| Surgical Procedure      | Date      |
| Other Pertinent Diagnoses      | Date      |
| Functional Limitations  | Activity Limitations |
| [ ]  Amputation | [ ]  Paralysis | [ ]  Legally Blind | [ ]  Independent mobility at home |
| [ ]  Bowel/Bladder (Incontinence) | [ ]  Endurance | [ ]  Shortness of Breath | [ ]  Walker |
| [ ]  Contracture | [ ]  Ambulation | [ ]  Speech | [ ]  Cane |
| [ ]  Other:       | [ ]  Wheelchair |
| [ ]  Other:       |
| Physician Orders: PERSONAL CARE SERVICES (DHS 107.112) (check areas that are specific to the client) |
| [ ]  | RN Supervisory visits of personal care services every 60 days |
| *Personal Care Worker to assist       times/day       times/week,*       *weeks/year:* |
| *For each area checked, specify the activity and frequency the client requires:*  |
| [ ]  | Assistance with bathing:       |
| [ ]  | Assistance with getting in and out of bed:       |
| [ ]  | Teeth, mouth, denture, and hair care:       |
| [ ]  | Assistance with mobility (limitations should be identified above):       |
| [ ]  | Changing the recipient’s bed and laundering the bed linens and the recipient’s personal clothing:       |
| [ ]  | Skin care excluding wound care:       |
| [ ]  | Care of eyeglasses and hearing aids:       |
| [ ]  | Assistance with dressing and undressing:       |
| [ ]  | Toileting (limitations should be identified above):       |
| [ ]  | Light cleaning in essential areas of the home used during personal care service activities:       |
| [ ]  | Meal preparation, food purchasing, and meal serving:       |
| [ ]  | Simple transfers including bed to chair or wheelchair and reverse (limitations should be identified above):       |
| [ ]  | Accompanying the recipient to obtain medical diagnosis and treatment:       |
| [ ]  | DELEGATED NURSING/MEDICALLY ORIENTED TASKS:       |
| [ ]  | Glucometer readings:       times/day,       times/week. RN to report to physician if blood glucose is less than       or greater than       |
| [ ]  | OTHER:       |
| Admission Nurse’s Name (printed) and Signature | Date of RN In-Home Assessment  |
| PHYSICIAN INFORMATION: |
| Physician’s Name | I certify/recertify that this patient has a need for the personal care services listed above and is *not solely supportive care*. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. |
| Physician’s Address |
| Attending Physician’s Signature | DATE OF PHYSICIAN SIGNATURE      |