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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-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 | | | | | | |