HW0603
Rev 10/95

State of Idaho-Department of Health and Welfare
PHYSICIAN'S MEDICAL CARE EVALUATION FOR ALTERNATIVE CARE PROGRAMS
PATIENT INFORMATION

Name: (Last, First, Middle initial)	Address: (Street, City, Zip)

Sex ☐ Male ☐ Female	Birthdate:	Medicaid Number

INSTRUCTIONS:
The Idaho Medicaid Program offers Personal Care Services and Home Care for certain Disabled Children as alternatives to institutional care for individuals eligible for or at risk of institutional placement. Your patient has applied for one or both of these programs. Please complete the following:

I. **CERTIFICATION:** I certify that my patient would require the following level of institutional care in the absence of an alternative care program. (see cover letter for definitions)

☐ Nursing Facility ☐ Does not require institutional care

☐ Intermediate Care for the Mentally Retarded

II. **PHYSICIAN ORDERS:** Alternative care programs

Personal Care Services _____________ Hours/day ______________ Days/week.

III. **MEDICAL ORDERS AND PLAN OF CARE:**

A: Medications: ____

____

____

B: Treatments (medical and habilitative) ____

____

C: Rehabilitative Potential (consider utilization of PT, OT, Speech Therapy, Respiratory Therapy, Social Services, and other ancillary services used in determining this potential.

____

____

D: Long Term Goals: ____

____

E: Current Functional Level:

1. ALL PATIENTS

Continence Level: ☐ Continent
☐ Incontinent of: ☐ Bladder
☐ Bowel
☐ Both

Mobility Status
☐ Ambulatory ☐ Ambulatory with assistance:
☐ Cane/Walker ☐ Wheelchair
☐ Non-mobile (bedfast/bed-chair)

Mental Status:

	Yes	No		Yes	No		Yes	No
Alert	☐	☐	Delusions	☐	☐	Depressed	☐	☐
Oriented	☐	☐	Hallucinations	☐	☐	Coma/Unconscious	☐	☐

Requires Human Help In:

Bathing ☐ Dressing ☐ Eating ☐ Transfers ☐ Toilet ☐ Assistance with Medication ☐

2. **CHILDREN ONLY (19 Years of age or under)**

Information concerning patient's acquisition of appropriate developmental skills and milestones:

____

____

____

IV. **RELEVANT HISTORY** (including surgical procedures and dosages): ____________________

____

____

____

____

V. EXAMINATION:

a. Head and Neck (general) ____________________

VISION:

Right Eye	Left Eye
☐ Normal ☐ Impaired	☐ Normal ☐ Impaired
☐ Blind ☐ Cataract	☐ Blind ☐ Cataract
☐ Corneal Scars	☐ Corneal Scars
☐ Other ____________________	☐ Other ____________________

HEARING:

Right Ear	Left Ear
☐ Normal ☐ Impairment: Degree __________	☐ Normal ☐ Impairment: Degree__________

b. Nose and Throat: ____________________

____

c. Chest and Lungs: ____________________

____

d. Heart and Circulatory: ____________________

____

e. Abdomen: ____________________

____

f. Genito-Urinary: ____________________

____

g. Ano-Rectal: ____________________

____

h. Neurologic: ____________________

____

i. Psychiatric (behavior, mood, stability): ____________________

____

j. Skin: ____________________

____

k. Musculo-Skeletal: ____________________

____

l. Other Significant Findings: ____________________

____

m. Height: __________ Weight: __________ Blood Pressure: __________ Pulse: __________

VI. **CLINICAL DIAGNOSIS:** Primary: ____________________

Secondary: ____________________

Other: ____________________

Prognosis: ____________________

VII. **ADDITIONAL COMMENTS:** ____________________

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VIII. NAME AND ADDRESS OF EXAMINING PHYSICIAN	Date of Examination: __________ Date of Report: __________ Physician's Signature: M.D.