

Fascimile Transmittal

To: Special Touch CRPU

Fax: 347-462-0190

From:

Date:

Re:

Pages:

 Urgent For Review Please Comment Please Reply Please Recycle**FAX THE COMPLETED FORM TO 347-462-0190****If you have any questions call 718-627-1122 and ask to speak with our Intake Department.**

Your patient's insurance WILL reject any M11Q that is not filled out in accordance with the following guidelines – this will result in a delay in the initiation of (or an interruption of) your patient's home care services.

Thank you for your assistance – we greatly appreciate the opportunity to provide your patient with best in class home care services.

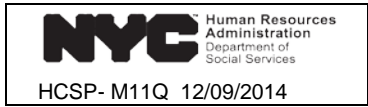
TIPS ON ACCURATE COMPLETION OF THE MEDICAL REQUEST FOR HOME CARE (M11Q)

- 1.The client's name, address, and Social Security number **MUST** be provided (Page 1).
- 2.The medical professional **MUST** complete the M11Q by accurately describing the patient's medical (Pages 1 & 2).
- 3.The medical professional **MUST NOT** recommend or request the number of hours of personal care services.
- 4.The M11Q **MUST** be signed by a NY State licensed physician.
- 5.The date of the examination (Page 1) **MUST** be provided.
- 6.The physician **MUST** sign and date the M11Q within 30 days after the exam date (Page 3)
- 7.The registry number, NPI (national provider ID), and the complete business address of the physician **MUST** be indicated (Page 3).
- 8.The completed signed copy of the M11Q **MUST** be submitted within 30 calendar days after the date of the examination ("date of exam" is on Page 1 - "date form completed" is on Page 3).

Notes: Is there anything else you would like us to know? Tell us here....

CONFIDENTIAL

MEDICAL REQUEST FOR HOME CARE



GSS District Office _____ Attn: Case Load No. _____

Return Completed Form to:

Address _____ Borough _____
 Zip Code _____ Tel. No. _____

Date Returned to/Received by GSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

Patient's Name	Birthdate	Social Security Number	Medicaid No.
Home address (No. & Street)		Borough	Zip Code
Telephone No.			
Hospital/Clinic Chart No.	II. MEDICAL STATUS		Contact Person
		Contact Tel. No.	

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

Date: _____ Signature(X) _____

How long have you treated the patient? _____ Date of this Examination: _____ Place of this Examination: _____ Date of next Examination: _____

A. CURRENT CONDITION

Date of Onset _____ Check(✓) prognosis of each

Date of Onset	1. Primary Diagnosis/ ICD Code	2. Secondary Diagnosis/ ICD Code	3.	4.	5.	Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
_____	_____	_____	_____	_____	_____			
_____	_____	_____	_____	_____	_____			
_____	_____	_____	_____	_____	_____			
_____	_____	_____	_____	_____	_____			

B. HOSPITAL INFORMATION

CURRENTLY IN: (Hospital Name) _____

Admission Date: _____

Reason for Hospitalization: _____

Expected Date of Discharge: _____

C. MEDICATION

	Dosage	Oral or Parenteral	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Indicate patient's ability to take medication: (*)

- 1. Can self-administer
- 2. Needs reminding
- 3. Needs supervision
- 4. Needs help with preparation
- 5. Needs administration

(*) If patient CANNOT self-administer medication

(a) Can he/she be trained to self-administer medication? Yes No If no, indicate why not: _____

(b) What arrangements have been made for the administration of medications? _____

D. MEDICAL TREATMENT

Does the patient receive any of the following medical treatment?
Indicate medical treatment currently received: (✓)

Yes No

1. Decubitus Care	
2. Dressings: Sterile Simple	
3. Bed bound Care (turning, exercising, positioning)	
4. Ambulation Exercise	
5. ROM/Therapeutic Exercise	
6. Enema	

7. Colostomy Care	
8. Ostomy Care	
9. Oxygen Administration	
10. Catheter Care	
11. Tube Irrigation	
12. Monitor Vital Signs	
13. Tube Feedings	
14. Inhalation Therapy	

15. Suctioning	
16. Speech/Hearing/ Therapy	
17. Occupational Therapy	
18. Rehabilitation Therapy	
19. Indicate any special dietary needs	
20. Other	

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

Yes No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

Can patient direct a home care worker? Yes No If no, explain below:

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane			
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

SSN: _____

