Geisinger

# Private Duty Nursing/Shift Care Form

Fax the completed form to 570-271-5507.

| Form completed by: | Date completed: |
|---|---|

## Physician and patient information

| Ordering physician: | Physician phone: | Physician fax: |
|---|---|---|
| Physician address: | | Date of last office visit: |
| Date(s) of last pediatric facility placement: | Pediatric facility new auth number: | |
| Date of last hospitalization: | Dx: | Facility: |
| Date of last ED visit: | Reason: | Facility: |

## Member information and services requested

| Member name: | Member ID: | Member DOB: |
|---|---|---|
| Member diagnosis: | | |
| ICD-10 codes (include all codes): | | |
| Services requested (e.g., SN or HHA shift care 8 hrs/night X 5 nights/week for caregiver's sleep; SN or HHA 6 hrs/day X 5 days/week for school accompaniment days): | | |

| Skill level requested (PDN): | RN T1002 ◯ | LPN T1003 ◯ | Home health aide G0156 ◯ | | |
|---|---|---|---|---|---|
| Monthly total hours | | | | | |
| Jan: | Feb: | Mar: | Apr: | May: | June: |
| July: | Aug: | Sept: | Oct: | Nov: | Dec: |

## Home health care provider (HHCP) (this section is optional)

| HHCP name: | HHCP contact phone: |
|---|---|
| HHCP contact name: | HHCP contact E-mail: |
| HHCP NPI: | HHCP contact fax: |

## Member's social history (this section is optional)

Caregivers available in the home and relationship (parent, guardian, foster parent):

**If care cannot be provided due to caregiver disability, attach letter from the caregiver's physician stating level of disability and restrictions related to inability to perform care of the member.**

Other individuals living in home:

**Indicate relationship to member, age, and if they receive shift care services; include foster siblings.**

| Are hours being requested to cover caregiver, parent, or guardian work schedules? | Work letter(s) attached: |
|---|---|
| Yes ◯ No ◯ | Yes ◯ No ◯ |
| If yes, how many? | **If self-employed, include EIN number, validation of working hours (trips sheets, timecards, time schedule). (this section is optional)** |

| Work letter(s) verified | | |
|---|---|---|
| Name: | Phone: | Date: |
| Name: | Phone: | Date: |
| Has a family member or caregiver been trained, competent, and willing to care for the member:<br><br>Yes ◯ No ◯<br><br>If no, please explain: | | |
| School district: | Method of transportation: | Total hours of school attendance daily, including travel time: |
| **Attach current school district calendar and letter from school. Letter must come from principal or director of special education on official letterhead stating why the school district is unable to accommodate the child's needs during school hours.** | | |

## Supporting clinical information

| | | | | |
|---|---|---|---|---|
| Ventilator: | Yes ◯ | No ◯ | Hours on ventilator/ ventilator type (BiPap, CPAP, traditional): | |
| Tracheostomy: | Yes ◯ | No ◯ | Trach type: | |
| Additional trach information (date inserted, trach size, frequency of trach care, frequency changed, etc.): | | | | |
| Oxygen: | Yes ◯ | No ◯ | Continuous ◯ | Intermittent ◯ |
| If intermittent, frequency: | Liter/minute: | | Route: | |

| | |
|---|---|
| Pulse Ox: Yes ◯ No ◯ | Continuous ◯ Intermittent ◯ |
| If Intermittent, frequency: | |
| Nebulizer: Yes ◯ No ◯ | Frequency: |
| Cough assist device: Yes ◯ No ◯ | Frequency: |
| Chest percussion: Yes ◯ No ◯ | Frequency: |
| Chest vest therapy: Yes ◯ No ◯ | Frequency: |
| IPBV machine: Yes ◯ No ◯ | Frequency: |
| Enteral feeding: Yes ◯ No ◯ | Formula and route: |
| Bolus feeds: Yes ◯ No ◯ | Amount: |
| Frequency: | Duration: |
| Continuous feeds: Yes ◯ No ◯<br>If yes, indicate total hours for continuous feedings with times and rate of administration: | |
| Complications with the feedings when infusing: Yes ◯ No ◯<br>If yes, explain (venting, etc.): | |
| PO feeds: Yes ◯ No ◯ | |
| Ostomy: Yes ◯ No ◯ | Type: |

| | | | |
|---|---|---|---|
| Incontinent of urine: Yes ◯ No ◯ | | | GI/GU descriptions (frequency of catheter care, frequency of incontinence, frequency of stoma care, etc.): |
| Incontinent of bowel: Yes ◯ No ◯ | | | |
| Urinary catheter: Yes ◯ No ◯ | | | |
| Wounds: Yes ◯ No ◯ | Number of wounds: | Locations and measurements: | |
| Frequency of wound care: | | Type of wound care: | |
| IV Catheter: Yes ◯ No ◯ | | Observation only: Yes ◯ No ◯ | |
| Type (Broviac, PICC, peripheral) and description: | | | |
| Interventions: Yes ◯ No ◯ | | If yes, explain: | |
| TPN: Yes ◯ No ◯ | Frequency: | Duration: | |
| Seizures: Yes ◯ No ◯ | | Seizure log attached: Yes ◯ No ◯ | |
| Avg. number per day: | | Avg. duration: | |
| Seizure interventions (VNS, Diastat, ketogenic diet, oxygen): | | | |
| Diabetes: Yes ◯ No ◯ | Insulin: Yes ◯ No ◯ | Insulin pump: Yes ◯ No ◯ | |
| Finger sticks/ Dexcom: Yes ◯ No ◯ | | Frequency: | |
| Ketone checks: Yes ◯ No ◯ | | Frequency: | |

| Interventions/education: |
|---|
| Additional diagnosis: |
| Treatments: |

| Environmental care assessment | Yes | No | Date | Initials |
|---|---|---|---|---|
| Adaptive equipment available/used:<br><br>List: | ☐ | ☐ | | |

| Ambulation/ADLs | Ambulatory: Yes ☐ No ☐ | | Requires assistance: Yes ☐ No ☐ | |
|---|---|---|---|---|
| | Independent | Supervision/verbal cues | Assist | Dependent |
| Bathing | | | | |
| Grooming | | | | |
| Dressing | | | | |
| Toileting | | | | |
| Repositioning | | | | |
| Transfers | | | | |
| Eating | | | | |
| Oral care | | | | |

| Weight check: Yes ☐ No ☐ | Frequency: |
|---|---|

Therapies:

**Describe therapies that are performed (e.g., range of motion)**

## Comments