



DIAMOND STATE PARTNERS

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Authorization /Diamond State
Partners
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8.2 PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

Name _____ Medicaid ID# _____

Address _____

Telephone Number _____ Date of Birth _____

Diagnosis _____

Prognosis and expectations of specific disease process _____

Date of last physician assessment _____

Approximate hours per day services required _____ hours

Approximate length of time services required: Weeks/Months. Specify length of time

Technology Requirements

1. Ventilator dependent YES NO Hours per day required on ventilator _____

2. Intravenous fluids/medications YES NO

Type of intravenous fluids/medications _____

Dose/frequency/duration _____

3. Enteral (Tube) feedings: Sole source of nutrition YES NO

Type of nutrition/frequency _____

4. Oxygen YES NO Liters per/min./hrs. per day _____

5. Non-ventilator dependent tracheostomy YES NO

Please attach letter of medical necessity also include medical history, plan of care (Requirements listed in "Medical Necessity Review and Payment Authorization for Private Duty Nursing"), completed Acuity and Psychosocial Grids and start of care date for private duty nursing care.

I agree that the individual is medically stable except for episodes that the Private Duty Nursing can manage.

Physician's Signature _____ Date _____

Fax or mail request within seven (7) working days before the start of care.