

REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services in order for him/her to remain at home. You are asked to indicate on this form what specific services are needed and what specific condition necessitates the services.

In-Home Supportive Services is authorized to fund the provision of paramedical services, if you order them for this patient. For the purpose of this program, paramedical services are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health and which the recipient would perform for himself/herself were he/she not functionally impaired. These services will be provided by In-Home Supportive Services providers who are not licensed to practice a health care profession and will rarely be training in the provision of health care services. Should you order services, you will be responsible for directing the provision of the paramedical services.

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met.

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE
--------	-------	------------------	------

TO BE COMPLETED BY LICENSED PROFESSIONAL

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE
-------------------------------	------------------

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

TYPE OF PRACTICE

Physician/Surgeon Podiatrist Dentist

CONTINUED ON BACK

RETURN TO: (COUNTY WELFARE DEPARTMENT)

Does the patient have a medical condition which results in a need for IHSS paramedical services?"

YES NO

Is YES, list the condition(s) below:

List the paramedical services which are needed and should be provided by IHSS in your professional judgement.

TYPE OF SERVICE	TIME REQUIRED TO PERFORM THE SERVICE EACH TIME PERFORMED	FREQUENCY*		HOW LONG SHOULD THIS SERVICE BE PROVIDED?
		# OF TIMES	TIME PERIOD	

* Indicate the number of times a service should be provided for a specific time period: (Example: two times daily, etc.)

Additional comments:

IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgement the services which I have ordered are necessary to maintain the recipient's health and could be performed by the recipient for himself/herself were he/she not functionally impaired.


I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE 	DATE
--	------

PATIENT'S INFORMED CONSENT

I have been advised of risks associated with provision of the services listed above and consent to provision of these services by my In-Home Supportive Services provider.

SIGNATURE 	DATE
--	------