Human Resources Administration
Home Care Services Program
Form M-11q (Page 1)
03/02

MEDICAL REQUEST FOR HOME CARE

RETURN COMPLETED FORM TO: GSS District Office_ Attn.: Case Load No._____

Address_____ Boro__

Zip Code_ Tel. No._____

Date Returned to/Received by GSS

FOR GSS USE ONLY

I. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	MEDICAID NO.

HOME ADDRESS (No. & Street)	BORO	ZIP CODE	TELEPHONE NO.

Hospital/Clinic Chart No.	Contact Person	Contact Tel. No.

II. MEDICAL STATUS

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	Anticipated Recovery in 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
_____	1. PRIMARY DIAGNOSIS _____			
_____	2. SECONDARY DIAGNOSIS _____			
_____	3. _____			
_____	4. _____			
_____	5. _____			

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. IMPAIRMENTS Does the patient have any of the following impairments? ☐ Yes ☐ No

If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT

	PARTIAL	TOTAL
1. Speech	☐	☐
2. Sight	☐	☐
3. Hearing	☐	☐

MUSCULAR/MOTOR IMPAIRMENT

	PARTIAL	TOTAL
1. Dominant hand/arm	☐	☐
2. Other hand/arm	☐	☐
3. Muscular Coordination	☐	☐
Upper Extremities	☐	☐
Lower Extremities	☐	☐

CARDIOVASCULAR/RESPIRATORY IMPAIRMENT

	PARTIAL	TOTAL
1. Respiratory function	☐	☐
2. Cardiac function	☐	☐
3. Circulation	☐	☐

ELIMINATION (Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder			
Bowel			

Indicate reason for incontinence and what is currently being done: _____

E. MENTAL STATUS - Does the patient exhibit any of the following? ☐ Yes ☐ No If Yes, check appropriate boxes.

	Some-times	Always		Some-times	Always		Some-times	Always		Some-times	Always
1. Disoriented to place/time	☐	☐	4. Short-term memory impairment	☐	☐	7. Impaired judgment	☐	☐	10. Communication problems	☐	☐
2. Anxiety	☐	☐	5. Wandering	☐	☐	8. Danger to others	☐	☐	11. Sleep Disorder	☐	☐
3. Agitation	☐	☐	6. Depression	☐	☐	9. Danger to self	☐	☐	12. Abusive	☐	☐

Describe the nature, frequency and effect on client's functioning for any area checked. Attach additional documentation if necessary.

Is patient alert? ☐ Always ☐ Sometimes ☐ Never

Can patient direct a home care worker? ☐ Yes ☐ No If No, explain below.

F. MEDICAL TREATMENT Does the patient need any of the following medical treatment? ☐ Yes ☐ No

Indicate medical treatment needed: (✓

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 feeding	
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.)

G. 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?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of:				
			Cane	Walker	Person	Other:	(Specify)
1. Ambulate inside							
2. Ambulate outside							
3. Get up from seated position							
4. Get up from bed							
5. Transfer to commode							
6. Transfer to wheelchair							

B. Indicate any services needed (✓)

A. CHORE SERVICES:

☐ Cleaning ☐ Meal Prep
☐ Laundry ☐ Shopping
☐ Reheat Meals

B. PERSONAL CARE SERVICES:

	Partial	Total
1. Grooming	☐	☐
2. Dressing	☐	☐
3. Washing	☐	☐
4. Bathing	☐	☐

	Partial	Total
5. Feeding	☐	☐
6. Toileting: Bedpan	☐	☐
Commode	☐	☐
7. Other special toilet needs:		

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? ☐ Yes * ☐ No

* Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

(PRINT) Physician's Name _____ Specialty _____ Physician's Signature _____ ☐ Intern ☐ Resident

Date Form Completed _____ Registry No. _____ Telephone No. _____ Hospital Contact Person _____ Telephone No. _____

Indicate where form was completed:

Hospital/Clinic/Inst. Name _____ Address _____ Telephone No. _____

If nurse/social worker/other person assisted in completing this form:

Name _____ Title _____ Address _____ Telephone No. _____

V. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	