Recommendation & Status Report

COASTAL CARE SERVICES, INC.®
member quality redefined.

Home Health Agency:_____ **Date:** _____ **S.O.C:** _____

Patient's Last Name:

First Name:

D.O.B:

Policy#:

Tel #:

Primary Diagnosis:				.		
Secondary Diagnosis:				.		
Addt'l Diagnosis:				.		

History of Present Illness: _____

Homebound, Describe Reason: _____

Teaching and training of patient/caregiver/ friend/ family: ☐ Possible ☐ Not Possible
Home Environment: ☐ Lives Alone ☐ Debilitated ☐Frail Elderly Caregiver ☐ Other:_____

Wound Care:

Type	Location	Dimensions	Drainage	Stage	Improving
		L_____cm x W_____cm x D _____cm			
		L_____cm x W_____cm x D _____cm			
		L_____cm x W_____cm x D _____cm			

(Agencies must submit a status report on all wound care cases on a weekly basis)
Has a physician been notified of Plan of Care: ☐ Yes ☐ No Next Physician Appt: _____

Medications being administered by Nurse: ☐ Yes ☐ No Indicate Medication: _____

AGENCY RECOMMENDATIONS/REQUEST

Discipline	# Visits	From	To	Specify Reason for Follow-up -Visit/Plan of Care/ Frequency

Provider Signature:_____ Date:_____

Comments:_____

Recommendation and Status Report Form must be submitted for review before the current authorization expires if recommendation is for services to be continued.