Home Health Services Recommendation & Status Report

The Urgent/Expedited service request designation should only be used if the clinician considers the member's health, life or ability to regain máximum function in serious jeopardy under the standard organization determination process. CLINICAL DOCUMENTATION must be included to support all request.

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			

(Wound care cases requires submission of status report on a weekly basis)

Has a physician been notified of Plan of Care: ☐ Yes ☐ No Next Physician Appt. Date: _____

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

AGENCY RECOMMENDATIONS/REQUEST

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

Clinician Signature: _____ **Date:** _____

Comments: _____

This Recommendation and Status Report Form must be submitted for review before the current authorization expires.