PRIMARY CARE PROVIDER REQUEST FORM
FOR PRIVATE DUTY NURSING

***Must be completed within 7 working days before start of care date and submitted to KEPRO Healthcare.**

Name: _____Medicaid ID#_____

Address: _____

Telephone Number: _____Date of Birth: _____

Diagnosis: _____

Prognosis and expectations of the 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: _____

3. **Enteral (Tube Feedings) Sole source of nutrition: _____YES _____ NO**

   Type of nutrition/frequency: _____

4. **Oxygen: _____YES _____NO**

   Liters per minute and hours per day required: _____

5. **Non-ventilator dependent tracheostomy: _____ YES _____NO**

   - **Please attach letter of medical necessity, also include medical history and start of care date for private duty nursing care.**

"I am in agreement that the individual is medically stable except for acute episodes that the Private Duty Nursing can manage."

Physician/APRN Signature: _____ Date: _____