Iowa Department of Health and Human Services

Physician's Report
Health Care Plan

Name (First, Middle, Last)				Telephone No. ( )	
Birth Date (MM/DD/YY)	Sex	Marital Status	Medicare No.	Medicaid No.	
Address			City	State	Zip Code
Other Health Insurance (Company Name)			Policy Holder	Policy No.	
Worker's Name		Worker's Office Address		Telephone No. ( )	

I. Statement of Client's Chief Complaints/Diagnosis/Prognosis: ______________________

____

____

II. Pertinent Findings

A. Physical Examination:

Height	Weight	Blood Pressure

Person has findings related to:	Yes	No	Unk	Findings	Needs Further Evaluation? Yes	No
1. HEENT	❑	❑	❑	______	❑	❑
2. Hearing	❑	❑	❑	______	❑	❑
3. Vision	❑	❑	❑	______	❑	❑
4. Dentition	❑	❑	❑	______	❑	❑
5. Respiratory	❑	❑	❑	______	❑	❑
6. Cardiovascular	❑	❑	❑	______	❑	❑
7. Gastrointestinal	❑	❑	❑	______	❑	❑
8. Genitourinary	❑	❑	❑	______	❑	❑
9. Dermatologic	❑	❑	❑	______	❑	❑
10. Musculoskeletal	❑	❑	❑	______	❑	❑
11. Orientation and thinking	❑	❑	❑	______	❑	❑
12. Affect	❑	❑	❑	______	❑	❑
13. Nutrition/hydration	❑	❑	❑		❑	❑

B. Laboratory (general blood test, urinalysis, etc): ______________________

____

____

C. T.B. Status (must be re-evaluated every 3 years): ______________________

D. Other communicable diseases: (if person has a contagious disease, please explain and give recommendations):

____

____

____

E. Immunizations: Diphtheria ______________ Tetanus ________________ Polio ____________________

III. Health Care Plan

Specific Health Care Service (Please provide orders/recommendations for the client's specific health care services, treatments, medications, diet, and other special instructions): ____________

Method of providing services identified above ____________

Expected duration of service ____________

IV. Physician's Certification:

Physician's Certification: I find this person to be free of clinical evidence of communicable disease and I believe the statement checked below indicates the optimal arrangement for this person.

- ☐ This person can live independently and from there receive any services needed.
- ☐ This person is essentially capable of physical self-care and has needs that can be met in a certified family-life home.[1]
- ☐ This person has health care needs and requires personal care (unskilled)services which can be met in the person's own home with in-home health-related care services.[2]
- ☐ This person has health care needs and requires skilled care services (technical and require training of provider) which can be provided in the person's own home with in-home health-related care services supervised by a supervising practitioner. [2]
- ☐ Other. This person needs the following living arrangement and services: ____________

Physician's Signature	Date	
Physician Name:	Office Address:	Office Number: Fax Number:

[1] A "family-life home" is a private house.

[2] "In-home health-related care" is a program of health care provided to persons in their own homes because they are unable to care for themselves adequately. Skilled services needed must be certified by a physician and supervised by a practitioner. Eligible practitioners include physician, nurse practitioner, clinical nurse specialist or physician's assistant.

V. Physician's Re-certification of Health Care Plan for IHHRC

Physician's Re-certification of Health Care Plan for IHHRC (required every 180 days, upon initiation of Medicaid waiver services, or more frequently as decided upon by physician or IHHRC service worker)

I find the plan outlined above to be appropriate for the client's care needs at this time.

Physician's Signature	Date
Physician's Signature	Date
Physician's Signature	Date
Physician's Signature	Date

This page is not required if only personal services are ordered/recommended by the physician. This page must be completed if the services provided are skilled services and are supervised by a supervising practitioner. Eligible supervising practitioner types are a physician, nurse practitioner, clinical nurse specialist or physician's assistant.

VI. Supervising Practitioner for IHHRC

I have reviewed the specific types of services required by the physician. I will work with the IHHRC care provider to ensure they are able to provide the skilled services as outlined.

As required by Iowa Administrative Code 441-177.8(2) and based on the skilled services ordered provided to the patient, I will review skilled services documentation completed by the IHHRC care provider every (circle one):

60 days **90 days** **180 days**

Supervising Practitioner's Signature:		Date:
Supervising Practitioner's Name:	Office Address:	Phone Number: Fax Number:

VII. Review by Supervising Practitioner for IHHRC (required as outlined above)

I have reviewed documentation that is specific to the services being provided to this patient. I have provided instruction to the IHHRC care provider on how to administer specific health care services to meet the client's needs.

Supervising Practitioner's Signature	Date
Supervising Practitioner's Signature	Date
Supervising Practitioner's Signature	Date
Supervising Practitioner's Signature	Date
Supervising Practitioner's Signature	Date

NOTE: Family Life Home Services require only sections I-V to be completed.

Please return the completed form to:

IHHRC Service Worker Name:	Address:	Email:	Phone: Fax: