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APPENDIX 15
HEALTHCARE INFORMATION REQUEST FORM

The Healthcare Information Request Form shall be utilized by Division of Senior and Disability (DSDS) staff completing reassessments when Level of Care (LOC) increases from a 21 to 24 or higher. For reassessments completed by providers, the form shall be completed by DSDS staff completing the provider reassessment review when LOC increases from a 21 to a 24 or higher. This form may also be used during any assessment when DSDS staff is unsure of participant's self-reported information and needs to verify with a physician.

This form may need to be sent to multiple physicians if applicable. For example, a participant may have a primary physician but monthly monitoring is done by a pulmonologist. In this case, both the primary physician and the pulmonologist receive the Healthcare Information Request Form. In addition, a provider nurse or other staff who has applicable information may complete the Healthcare Information Request Form.

As a best practice and when time allows, the assessor will call the physician's office and notify them the form will be faxed and the reason for the request. If the form is not returned to the assessor within 7-8 business days, the assessor shall call the physician, or other healthcare professional, and follow-up. If no response is received from the physician within 10 business days, staff shall proceed with the information gathered during the original assessment.

When the form is returned, the assessor shall update the assessment as needed with new information from the physician to determine if there is a change in LOC based on the new information.

NUMBER OF COPIES

One copy of the form shall be completed per physician or healthcare professional contacted.

INSTRUCTIONS

TO: Enter the physician's name and address.

PATIENT'S NAME: Enter the participant's name.

DOB: Enter the participant's date of birth.

DCN: Enter the participant's Departmental Client Number (DCN).

LEVEL OF CARE CATEGORIES (Medications, Treatments, etc.): Enter and verify LOC in all categories, unless this information has been validated in another way. Example: the assessor reviewed prescriptions in home (all bottles were verified to be current) and there is no need to confirm with physician or healthcare professional. LOC categories that have already been validated may be left blank or deleted from the form prior to sending to the physician. The physician or healthcare professional shall indicate YES or NO on information provided.

STAFF SIGNATURE: The individual completing the form shall sign the document.

STAFF NAME: The individual completing the form shall print their name.

DATE: Enter the date the form is completed.

ADDRESS: Enter the business mailing address of the DSDS staff.

FAX NUMBER: Enter the fax number of the DSDS staff.

DSDS STAFF COMMENTS: Staff may use this section to provide additional information to the physician.

PHYSICIAN COMMENTS: The physician or healthcare professional shall explain the YES or NO answer in the LOC categories.

DISTRIBUTION: The completed and returned form(s) shall be uploaded to the participant's case record in Web Tool.