4.00
APPENDIX 15
HEALTHCARE INFORMATION REQUEST FORM

The Healthcare Information Request Form may be utilized by the Division of Senior and Disability (DSDS) during the interRAI assessment process to verify participant self-reporting information with the physician. For reassessments completed by providers, the form may be completed by the Provider Review Team.

The completed form will be sent to all physicians whom the participant sees regularly. A provider nurse or other staff who has applicable information may also complete the form.

As best practice and when time allows, DSDS staff may call the physician's office and notify them that the form will be faxed, emailed or mailed and explain the reason for the request. If the form is not returned by the case due date, DSDS staff shall proceed with processing utilizing the information gathered during the original assessment.

When the form is returned, DSDS staff shall update the assessment as needed with the information provided by the physician to determine if there is a change in LOC.

NUMBER OF COPIES

One copy of the form will be sent 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: Enter the self-reported information and needs provided by the participant or responsible party in each of the LOC categories. LOC categories that have already been validated by other means may be left blank prior to sending to the physician. For example, the assessor witnesses the participant's difficulty moving to a standing position, inability to climb stairs or unsteady gait. If there is no other need to confirm with the physician or healthcare professional regarding the participant's mobility, the category can be left blank.

PHYSICIAN RESPONSE: The physician or healthcare professional indicates YES or NO on the information provided by DSDS staff

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

PHYSICIAN COMMENTS: The physician or healthcare professional may use this section to further explain the YES or NO answer in the LOC categories.

PHYSICIAN or HEALTHCARE PROFESSIONAL SIGNATURE and DATE: The individual responding to the form shall sign and date the document.

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.

DISTRIBUTION

The completed and returned form(s) shall be uploaded to the participant's electronic case record.