PRIMARY CARE PROVIDER REQUEST FORM
FOR PRIVATE DUTY NURSING

Must be completed within 7 working days before start of care date and submitted to APS 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:_____