

**Medicaid Home and Community-Based Waiver
ADULT DAY HEALTH CARE – NURSING
Physician's Orders**

To:

From:

Phone:

Fax:

The client identified below participates in a Medicaid home and community-based waiver and has requested Adult Day Health Care-Nursing services. Please evaluate your patient's appropriateness for this service by completing and signing this form, noting any restrictions or special instructions. Please mail or fax this form to the above address. Thank you for your assistance in providing this service.

Participant:

Medicaid ID:

ADHC – Nursing is limited to the following 6 skilled procedures:

1. **Ostomy Care**

Orders:

2. **Catheter Care**

Orders:

3. **Decubitus/Wound Care**

Orders:

4. **Tracheostomy Care**

Orders:

5. **Tube Feedings**

Orders:

6. **Nebulizer Treatment**

Orders:

Physician Signature:

Date:

ADHC Nurse Signature:

Date:

Date mailed to MD:

Date: