

PART C

TO BE COMPLETED BY LONG TERM CARE FACILITY

Nursing Services:	Daily	If NOT Daily Hrs/Mins per week	Date
1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
2. Assistance in dressing, eating, and going to the toilet;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
3. Levin tube and gastrostomy feedings;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
4. General maintenance care of colostomy and ileostomy;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
5. Nasopharyngeal and tracheotomy aspiration;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
6. Routine services to maintain satisfactory functioning of indwelling bladder catheters;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
7. Insertion and sterile irrigation and replacement of catheters;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
8. Changes of dressings for noninfected postoperative or chronic conditions;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
9. Application of dressing involving prescription medications and antiseptic techniques;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
10. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems.	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
11. Treatment of extensive decubitus;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
12. General supervision of exercises which have been taught to the patient including the actual carrying out of maintenance programs.	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□

Nursing Services:	Daily	If NOT Daily Hrs/Mins per week	Date
13. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment: for example, the institution and supervision of bowel and bladder training programs (does not include toileting).	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
14. Routine care of the incontinent patient, including use of diapers and protective sheets;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
15. Heat treatments which have been specifically ordered by a Physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
16. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
17. Initial phases of a regimen involving administration of medical gases;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
18. Routine administration of medical gases after a regimen of therapy has been established;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
19. Administration of routine oral medications, eye drops and ointments;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
20. General maintenance care in connection with a plaster cast;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
21. Routine care in connection with braces and similar devices;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□
22. Periodic turning and positioning in bed;	_____	□ □	From: □□-□□-□□□□ To: □□-□□-□□□□

PART D**TO BE COMPLETED BY EXTENDED OR LONG TERM CARE FACILITY**

Special Rehabilitation Therapy: Physical Therapy Speech Therapy Occupational Therapy
 Performed by or under the Supervision of a qualified Physical Therapist, Occupational Therapist or Speech Therapist. *(Please indicate need, type and frequency. Also include copies of therapy notes and charts.)*

Medications, Supplies, and Appliances: (include meds.)

Item	How Given	Frequency

Please explain any care being given not indicated elsewhere:

Please attach a copy of your State License and a copy of the Doctors orders. Doctors orders should be updated as changed or at least every six months.

Signature of person completing form: _____

Printed Name of person completing form: _____