PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

This form must be completed by the Parent or Legal Guardian's Physician.

Date: _____

Patient Name: _____

Physician Name: _____

Physician Address: _____

_____

Physician Telephone Number: (_____) _____

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

_____

_____

_____

_____

_____

_____

_____

If limitation/disability is temporary, please document the expected timeframe for resolution.

_____

Signature of Physician: _____

National Provider Identifier: _____

Signature of Parent/Legal Guardian:_____
(By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.)

For use by the Provider:

Recipient's Name: _____ Recipient Medicaid ID: _____