Name of PPEC: _____

PHYSICIAN PLAN OF CARE FOR PPEC SERVICES

Start of Care Date:	Date of last PE/medical exam:	Certification Period: From: To:	Medicaid ID #:	Provider No.

Child's Name	**ALLERGIES**
Parent/Guardian:	Phone number:

DOB:	Sex:	Provider Name and phone number:

Current Diagnoses	ICD	Secondary Diagnoses	ICD	Surgical Procedures	ICD

FUNCTIONAL LIMITATIONS
☐ Ambulation ☐ Amputation ☐ Cognitive ☐ Contracture
☐ Developmental Disabilities(fine, gross, oral-motor/speech language)
☐ Endurance ☐ Hearing ☐ Paralysis ☐ Speech
☐ Totally Dependent ☐ Vision
☐ Other

REHABILITATION POTENTIAL
☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor ☐ None
☐ Uncertain

MENTAL STATUS
☐ Alert ☐ Oriented ☐ Agitated/Irritable ☐ Lethargic/Non-responsive
☐ Infant ☐ Toddler ☐ Pre-School ☐ School

PATIENT ACTIVITY
☐ Sedentary(Bed, Stander, Adaptive Devices) ☐ Reposition/Turn Freq: _____ ☐ As Tolerated ☐ Unrestricted ☐ Other _____
☐ Within functional limitations/developmental level

PRECAUTIONS
☐ Universal ☐ Seizure ☐ Reflux ☐ Respiratory ☐ Child Safety ☐ Aspiration ☐ FX precautions ☐ Other _____

PRESCRIBED SERVICES

MEDICATIONS	Dose	Frequency	Route	MEDICATIONS	Dose	Frequency	Route

Other Special Orders/Instructions:

INFUSION THERAPY

☐ TPN ☐ Drugs/Fluids Type: _____ Total Volume(ml./hr._____) Freq./Duration: _____ ☐ Other
Route: ☐ PIV ☐ PICC ☐ Central Line type: _____ ☐ Mediport IV Site _____ ☐ Change Freq: _____ ☐ Dressing change q: _____

Diagnostic/Laboratory Studies:

AIRWAY MANAGEMENT

☐ Oxygen @ _____ Route _____
☐ Continuous ☐ PRN
☐ Maintain O_2 sats at > _____%
☐ Oxygen via NC/mask/ambu-bag up to _____/lpm in an emergency situation
☐ Humidity:
Type: ☐Air ☐O_2 ☐Thermovent

☐ Pulse Oximetry Freq: _____
☐ Spot checks q _____
☐ Cardiac/Respiratory monitor – Freq: _____
Settings: (_____) high limit (_____) low limit with a (_____) sec delay

☐ Trach Size/Type _____Trach care q _____
☐ Soap and water or ☐ ½ st H202
Change trach q _____ Change trach ties q_____
☐ Suction q_____
☐ CPT q _____ ☐ PRN
☐ Manual ☐vibrator ☐Vest

☐ Ventilator Type: _____
Mode ☐ CPAP ☐ BiPAP ☐ PSV ☐ CMV ☐ Assist control ☐ SIMV Other _____
Settings _____
☐ Oxygen _____FiO2/LPM ☐ Alarm limits: High _____Low _____ ☐ Heater Temp _____degrees Other _____

Child's Name: _____

NUTRITION / DIET ☐ NPO ☐ PO ☐ ENTERAL

Formula Type	Age Appropriate Diet	Amount	Route	Frequency	Other

☐ Weight q _____ ☐ Height q _____ ☐ Fax or call weights to MD q _____ ☐ Head circumference q _____ ☐ Chest circumference q _____
☐ ABD Circumference q _____ ☐ Other

☐ **Feeding Tube Care** Type: _____ Size: _____
☐ Flush q _____ with _____ Amount _____
☐ Change or replace feeding tube q _____ ☐ PRN
☐ Site assessment Frequency _____
☐ Other _____

☐ **Ostomy Care** Type: _____
☐ Change q _____
☐ Irrigate q _____ with _____
☐ Other _____

☐ **Catheter Care**
☐ Cath. Type _____ ☐ Site _____
☐ Frequency q _____ Type: _____

☐ **Misc. Care**
☐ Skin ☐ Oral ☐ Perineal ☐ ENT ☐ Wound ☐ Cast ☐ ADL's
☐ Other _____

GENERAL CARE

☐ Nurse to complete daily head-to-toe assessment.
☐ TPR daily and prn ☐ Daily I&O ☐ BP q _____ and prn with parameters of _____ ☐ Capillary refill daily and prn
☐ Daily Hygiene Requirements
☐ Nurses to do daily follow-up of developmental therapies/goals including but not limited to ROM and in accordance with therapists plan of care.
☐ Daily medication administration – monitor effects
☐ Nurse to assess family/caregiver knowledge & compliance with child's care needs and provide education/reinforcement of skills as indicated.
☐
☐

EQUIPMENT/SUPPLIES

☐ Oxygen/Tubing	☐ Nasal Cannula	☐ Trach	☐ Trach Ties	☐ Trach Collar	☐ Humidivents
☐ Vent/Circuits	☐ Compressor	☐ Humidifier	☐ Concentrator	☐ Fisher Paykel	☐ Ambu-bag
☐ Suction machine	☐ Suction catheters	☐ Pulse Oximeter	☐ Pulse-ox Probes	☐ A/B Monitor	☐ Belts/Leads-A/B monitor
☐ Nebulizer machine	☐ Nebulizer kits	☐ Feeding Pump	☐ Feeding Bags	☐ Feeding Tubes	☐ Protective Equipment
☐ Glasses	☐ Hearing- aides	☐ Hand-splints/DAFO/AFO's	☐ CPT vests	☐ Prosthesis	☐ Other

Therapeutic Services: ☐ PT : Freq. _____ ☐ OT : Freq. _____ ☐ ST : Freq. _____ ☐ Developmental Stimulation ☐ Visual Therapy
☐ Hearing Therapy ☐ Special Education ☐ Other _____

Hospitalizations (within last 6 months):

Current Medical Condition:

Risk Factors associated with Medical Diagnoses:

Goals:

For Recertification only: Accomplishments toward goals; Assessment of effectiveness of services:

Discharge Plans:

Nurses Signature and Date

Date PPEC Received Signed POC
_____/_____/_____

I certify/recertify that I am the attending physician for this pediatric patient. I authorize this plan of care and will periodically review the plan. In my professional opinion, the services listed on this plan of care are medically necessary and appropriate in amount, duration, and scope due to the child's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein.

Frequency and Duration of PPEC Services: _____ days/week _____ hours/day (partial or full) _____ Duration

Physician's Name and Address:

Physician's Signature and Date Signed:

FOR PPEC USE ONLY

PA AUTH PERIOD _____/_____/_____ to _____/_____/_____ PRIOR AUTH # _____

AHCA FORM 5000-3507