REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services in order for him/her to remain at home. You are asked to indicate on this form what specific services are needed and what specific condition necessitates the services.

In-Home Supportive Services is authorized to fund the provision of paramedical services, if you order them for this patient. For the purpose of this program, paramedical services are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health and which the recipient would perform for himself/herself were he/she not functionally impaired. These services will be provided by In-Home Supportive Services providers who are not licensed to practice a health care profession and will rarely be training in the provision of health care services. Should you order services, you will be responsible for directing the provision of the paramedical services.

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met.

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE

TO BE COMPLETED BY LICENSED PROFESSIONAL

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

TYPE OF PRACTICE

☐ Physician/Surgeon ☐ Podiatrist ☐ Dentist

CONTINUED ON BACK

RETURN TO: (COUNTY WELFARE DEPARTMENT)

Does the patient have a medical condition which results in a need for IHSS paramedical services?" ☐ YES ☐ NO
Is YES, list the condition(s) below:

List the paramedical services which are needed and should be provided by IHSS in your professional judgement.

TYPE OF SERVICE	TIME REQUIRED TO PERFORM THE SERVICE EACH TIME PERFORMED	FREQUENCY*		HOW LONG SHOULD THIS SERVICE BE PROVIDED?
		# OF TIMES	TIME PERIOD	

* Indicate the number of times a service should be provided for a specific time period: (Example: two times daily, etc.)

Additional comments:

SEE ADDENDUM TO THIS SOC 321

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgement the services which I have ordered are necessary to maintain the recipient's health and could be performed by the recipient for himself/herself were he/she not functionally impaired.

I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE ▶ | DATE

PATIENT'S INFORMED CONSENT

I have been advised of risks associated with provision of the services listed above and consent to provision of these services by my In-Home Supportive Services provider.

SIGNATURE ▶ | DATE

ADDENDUM TO SOC 321

Type of Paramedical Service	How many times a Day?	Time to do the service each time	How many months/years?
injections			
breathing treatments, nebulizer			
pulmonary toileting (pounding lung areas of back and chest to loosen secretions			
catheter changes or helping void urine with a catheter			
ostomy or bricker bag irrigation or changes and cleaning and maintaining the stoma site			
range of motion exercises and other home therapy programs prescribed by a physician			
nasal-gastric tube or G-Tube feedings & care of stoma site			
skin and wound care if there is a decubitus ulcer (bed or pressure sore) or a diabetes related wound or, if the person has a history of ecubiti, checking the body for "hot spots" that could turn into a decubitus ulcer			
including tracheal (deep) suctioning			
bowel program for those with spinal cord injuries or neurological bowel program for those with spinal cord injuries or neurological impairment impacting the gastro-intestinal system			
digital stool removal			
insertion of suppositories or administration of an enema			
adjustment, monitoring and connecting tubing and ventilator; C- PAP or BiPAP machine adjustment, putting on mask			

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I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE

DATE