PATIENT'S NAME	SSN	DOB

DATE PATIENT LAST SEEN BY YOU	DATE PATIENT BEGAN BEING SEEN BY YOU

Duration of this need? ☐ 3 Months ☐ 6 month ☐ 1yr ☐ Indefinite

Please check the level of assistance required	None	Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement	Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.	Can perform a function but only with substantial human assistance.	Cannot perform the function, with or without human assistance.	Other children of the same age do not routinely need this service
1. Preparation of meals	☐	☐	☐	☐	☐	☐
2. Meal Clean-Up	☐	☐	☐	☐	☐	☐
3. Feeding	☐	☐	☐	☐	☐	☐
4. Bed Baths	☐	☐	☐	☐	☐	☐
5. Bathing, Oral Hygiene,	☐	☐	☐	☐	☐	☐
6. Dressing	☐	☐	☐	☐	☐	☐
7. Bowell & Bladder Care	☐	☐	☐	☐	☐	☐
8. Reposition & Rubbing Skin	☐	☐	☐	☐	☐	☐
9. Transferring from Bed	☐	☐	☐	☐	☐	☐
10. Ambulation	☐	☐	☐	☐	☐	☐
11. Bowell & Bladder	☐	☐	☐	☐	☐	☐

I certify that I am licensed to practice in the State of California and that all information provided above is true and correct.

Physician Signature _____ MD Provider # _____Date:_____