

**PEDIATRIC PATIENT REVIEW INSTRUMENT
FOR CARE AT HOME WAIVER PROGRAM**

Date: _____

ADMINISTRATIVE DATA

Patient Name: _____

Birthdates: _____ Sex: Male Female

If child could not be cared for at home he/she would require:

SNF Hosp. Other level of care

County of Residence: _____

Diagnosis:

Primary: _____

Other: _____

Brief description of child's illness: (including age of on-set)

Family Structure (involvement, limitations, etc.)

MEDICAL TREATMENTS: (check all which apply)

	YES	NO		YES	NO
Trach Care			Total Parental Nutrition (TPN)		
Suctioning			Home Dialysis		
Oral/nasal			Monitoring device(s):		
Trach.			oximeter		
Oxygen			apnea		
Daily			cardiac		
Intermittently			Shunt Care		
Ventilator			VP		
Continuous			VA		
Intermittent			Shunt has functioned without a problem for last 6 months		
Feeding					
By mouth					
Nasal gastric feeding					
Parenteral (IV)					
Gastric Tube					
Other:					

FUNCTIONING

DOMAINS OF FUNCTIONING: Circle the number of the answer best describing this child's functioning **compared to a peer of the same age without problems**. Answers should be based on personal knowledge and available documentation. Severe problems are those requiring intensive treatment efforts. Lots of hands-on are and close supervision.

<u>DEVELOPMENTAL DOMAIN</u>	<u>SUSPECTED PROBLEM/ ASSESSMENT PENDING</u>	<u>MODERATE PROBLEM</u>	<u>SEVERE PROBLEM</u>	<u>NOT APPLICABLE/ AGE INAPPROP./ DON'T KNOW</u>
a. Gross motor	1	2	3	0
b. Fine motor	1	2	3	0
c. Receptive communication	1	2	3	0
d. Expressive communication	1	2	3	0
e. Self-care				
Toileting	1	2	3	0
Personal hygiene	1	2	3	0
Grooming	1	2	3	0
Eating	1	2	3	0
Bathing	1	2	3	0
Dressing	1	2	3	0
f. Vision	1	2	3	0
g. Hearing	1	2	3	0

	Yes	No	Comments
<p>Mobility</p> <p>a) Child is age appropriate</p> <p>b) If child is not age appropriate cont.:</p> <p>Requires assistance of another human to ambulate</p> <p>Ambulate</p> <p>Requires device to ambulate:</p> <p>wheelchair</p> <p>walker</p> <p>prosthesis</p> <p>Respiratory Care:</p> <p>Postural drainage</p> <p>Inhalation therapy</p> <p>Wound Care:</p> <p>Sterile</p> <p>Unsterile</p> <p>Catheter Care</p> <p>Seizures</p> <p>Intervention daily</p> <p>1 x mo.</p> <p>1 x in past 3 mos.</p> <p>1 x in past year</p> <p>Ostomy</p> <p>Orthotics</p> <p>Ongoing medication by NG</p> <p>G-tube</p> <p>Mental Status</p> <p>Alert</p> <p>Lathargic</p> <p>Stuperous</p> <p>Comatose</p> <p>Agitated</p>			

	Yes	No	Comments
a. Daily intravenous medication or nutritional supplement			
b. Requires constant observation for: _____			
c. Physical occupational or speech therapy			

Completed by: _____ R.N. Date completed _____

Title of Person Completing Form: _____

ADDITIONAL COMMENTS ABOUT CHILD:

If you have any questions about completing this form, please call Liz Morales at The New York State Department of Health at (518) 486-6562.