ADULT DEVELOPMENTAL DISABILITY MEDICAL CARE FORM

Please Complete This Form and Return to Participant

Participant Name:	Birth Date:

Should be seen by a physician ☐ Annually ☐ Other (please specify) _____

Is the Participant capable of self-administration of medication? ☐ Yes ☐ No

List of prescribed medications: _____

_____

_____

Health Issues:

Primary Developmental Disability Diagnosis: _____

Secondary Developmental Disability Diagnosis: _____

Mental Health Diagnosis: _____

Other Medical Diagnosis: _____

Relevant History (including treatments, surgeries) _____

_____

Vision: ☐ Normal ☐ Impaired ☐ Blind **Hearing:** ☐ Normal ☐ Impaired ☐ Deaf	Are there Durable Medical Needs? ☐ Yes ☐ No If yes please list: _____ _____

The Participant would benefit from the following services:

☐ Speech Therapy Assessment	☐ Substance Abuse
☐ Occupational Therapy Assessment	☐ Hospice
☐ Physical Therapy Assessment	☐ Diabetes Education
☐ Psychological Assessment	☐ Mental Health
☐ Dementia / Alzheimer's Education	☐ Weight Management
	☐ Other: _____

Are nursing services referred? ☐ Yes ☐ No

Is Developmental Therapy referred? ☐ Yes ☐ No

(Developmental Therapy is a skill building service which improves the person's quality of life by developing increased independence to manage tasks of daily living i.e. self-care, mobility, meal prep, etc.)

This form meets the referral requirements for Nursing Service or Developmental Disability Agency (DDA) services.

Options for Billing: Completion of the form using 99450 for examination or completion of form using 99080 from a record review using the diagnostic code Z02.89 (ICD-10-CM). Codes payable 2 times per calendar year or one each when combined per calendar year.

Date of Examination: _____ **Date of Report:** _____ **Physician's Signature:** _____ **Physician PRINT name:** _____	**If the form cannot be completed at the visit, please fax to Liberty Health Care at:** **Fax Number: (208)258-7985** **Name and Address of Examining Physician:** _____ _____ _____