

ADULT DEVELOPMENTAL DISABILITY MEDICAL CARE FORM

<u><i>Please Complete This Form and Return to Participant</i></u>	
Participant Name: _____	Birth Date: _____
Should be seen by a physician <input type="checkbox"/> Annually <input type="checkbox"/> Other (please specify) _____	
Is the Participant capable of self-administration of medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List of prescribed medications: _____ _____ _____	
<u>Health Issues:</u>	
Primary Developmental Disability Diagnosis: _____	
Secondary Developmental Disability Diagnosis: _____	
Mental Health Diagnosis: _____	
Other Medical Diagnosis: _____	
Relevant History (including treatments, surgeries) _____ _____	
Vision: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Blind Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Deaf	Are there Durable Medical Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please list: _____ _____
<u>The Participant would benefit from the following services:</u>	
<input type="checkbox"/> Speech Therapy Assessment <input type="checkbox"/> Occupational Therapy Assessment <input type="checkbox"/> Physical Therapy Assessment <input type="checkbox"/> Psychological Assessment <input type="checkbox"/> Dementia / Alzheimer's Education	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Hospice <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Mental Health <input type="checkbox"/> Weight Management <input type="checkbox"/> Other: _____
Are nursing services referred? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Developmental Therapy referred? <input type="checkbox"/> Yes <input type="checkbox"/> 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 referral starts at the Date of Examination and terminates on _____ or one year from the Date of Examination.	
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: _____ _____ _____