- **Ambulation.** Indicate the patient's ability to ambulate independently, or with the need for assistance or devices. Specify assistance/devices used or needed.
- **Bowel/Bladder.** Indicate if the patient is continent. Describe any catheter or colostomy needs.
- **Medications Required**. List all prescription and over-the-counter medications the patient is taking and note dosage, frequency and any special instructions.
- **Medication Administration**. Indicate the patient's ability to self-administer medications.
- **Dietary Needs.** Indicate if the patient has special nutritional or dietary needs, i.e. low salt or high potassium.
- **Tasks/Treatments/Therapies.** Indicate any tasks, treatments or therapies which the patient receives or requires in the home and describe.
- **Need for completion/assistance with skilled tasks.** If the patient requires assistance with skilled tasks including, but not limited to, glucose monitoring, wound care, vital signs, describe the need for such assistance.
- **Recommendation to provide assistance.** Check **Yes** if, in your opinion, the patient can be maintained in his or her home with provision of home care services.
- **Contributing factors to need for assistance**. Please indicate the functional deficits that support the need for the provision of home care services. Please include any pertinent information you may have regarding the patient's surroundings, physical condition or other factors that may affect the ability of the patient to function in the community or the patient's need for assistance with personal care tasks.

4. **Physician's Signature/Date of completion.** The signature of the ordering physician as identified in Item 2. Note that by signing this document, the physician certifies that the patient's condition and needs are accurately described. Forms lacking a signature and/or date are not acceptable.

5. **Return Form To.** The local district or other case management entity to whom the form is to be returned.