# Request for Order and Consent - Paramedical Services

**ADOPT**

| PATIENT'S NAME |
|---|
| IHSS CASE NUMBER |

**DRAFT**

~~Month Day, 20XX~~

~~Dear Licensed Health Care Professional (LHCP):~~

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services for him/her to remain safely at home. Please indicate on this form what specific paramedical services are needed by completing sections 1-5 of this form.

For the purposes of IHSS, paramedical services are services that require judgment based on training provided by a licensed health care professional (LHCP) licensed pursuant to Division 2 of the Business and Professions Code, that are necessary to maintain the patient's health and that he/she would normally perform for himself/herself if not for his/her functional limitation(s); such as: the administration of medications, puncturing the skin or inserting a medical device into a body orifice, ~~and~~ activities requiring sterile procedures, ~~among other things~~ or other activities requiring judgement based on a training given by an LHCP. These services will be provided by IHSS providers who are not licensed to practice health care and are not medically trained. If you order paramedical services, ~~you are responsible for ensuring that~~ the IHSS provider ~~is~~ must be trained to administer the paramedical services.

The time indicated to perform a specific paramedical service shall not be based on the ability of the IHSS provider to perform a task, but rather on the time it would take a~~n average person~~ trained IHSS provider who exercises average care, skill and judgement to perform the task for this patient, taking into account the patient's functional limitations. The Paramedical Services Authorization Reference Tool (Reference Tool) ~~Statewide Paramedical Services Time Guidelines are~~ is attached for you to use as a guide, and provides a list of common paramedical tasks with typical ~~range of~~ time ranges it would take a trained IHSS provider to perform each task.~~, which allows for variation~~ The required time may vary based on the individual needs of the patient. If the time necessary to perform the task for this patient ~~falls outside of~~ exceeds the timeframes listed in the attached Reference Tool ~~Statewide Paramedical Services Time Authorization Guidelines (Time Guidelines)~~, you must provide a description of how the recipient's functional limitation necessitates that authorization of the additional time ~~justification for the time ordered~~. *If you do not provide the required description necessitating ~~justification for indicating an amount of~~ additional time that is outside the range specified in the Reference Tool ~~Time Guidelines~~, the county will contact you to obtain this information prior to authorizing the paramedical services.* (Emphasis added.) *~~authorize time based on the in-home assessment and the Time Guidelines~~.*

You may authorize a paramedical service not listed on the Reference Tool as long as it meets the definition of a paramedical service as indicated above and the amount of time authorized is solely based on the recipient's need and not based on a provider's inability to perform a task efficiently.

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided

that all other applicable Medi-Cal provider requirements are met through the Department of Health Care Services (DHCS). You should submit billing to DHCS for payment for this office visit as you would with all other reimbursable Medi-Cal services.

## PARAMEDICAL SERVICE AUTHORIZATION REFERENCE TOOL

| CATEGORY/SPECIFIC TASK | TIME RANGE *(In Minutes)* |
|---|---|
| **BLADDER CARE** | |
| ▪ Bladder irrigation | 10-15 |
| ▪ Catheter Insertion (Intermittent or Foley) | 10-20 |
| ▪ Catheter Site Care | 5-10 |
| ▪ Catheter Bag Change | 5-10 |
| ▪ External Catheter (Condom Catheter) Replacement | 5-10 |
| **BOWEL CARE** | |
| ▪ Insertion of suppository | 1-3 |
| ▪ Digital Stimulation (Does not include wait time between passes) | 5-10 |
| ▪ Digital Stool Removal (Does not include wait time between passes) | 5-15 |
| ▪ Enema (Ready to Use) | 5-10 |
| ▪ Enema (Prep Required) | 10-15 |
| ▪ Ostomy Irrigation | 10-15 |
| ▪ Ostomy Site Care/Bag Change (1 or 2 piece) | 5-15 |
| ▪ Abdominal Manual Motility | 5-15 |
| ▪ Suppositories | See Medication Administration |
| **DIALYSIS** | |
| ▪ Continuous Ambulatory Peritoneal Dialysis | 10-30 |
| ▪ Automated Peritoneal Dialysis | 30-45 |
| ▪ Site Care | 5-10 |
| ▪ Mixing Dialysate | 10-20 |
| ▪ Weekly maintenance (lab work, drain line maintenance) | 20-40 |
| **FEEDING TUBES (GT/NG/JG)** | |
| ▪ Via Pump (prep formula, set-up and program pump, connect, disconnect, address alarms, flush, and clean up) | 10-20 |
| ▪ Without Pump (Gravity) | 10-20 |
| ▪ Syringe (Bolus) Syringe (Bolus) (prep, connect/disconnect/flush) | 10-20 |
| ▪ Flush/Give Water (through out the day) | 2-5 |
| ▪ Site Care/placement/residual check/balloon check (fill/refill) | 2-5 |
| ▪ Venting (or Ferrell bag) | 2-5 |
| ▪ GT Change | 5-15 |
| ▪ GT/NG/JG Medications | See Medication Administration |

## INTRAVENOUS (IV) FLUIDS

- Hang IV fluids (inclusive of preparation/takedown with before/after flushes) .......... 10-15
- Change Fluids or Piggyback (no new tubing)........................................................ 3-5
- IV infusion troubleshooting/ addressing alarms...................................................... 1-5
- IV flush (per flush)........................................................................................... 2-3
- Total parenteral nutrition (TPN) – with lipids ....................................................... 10-30
- Total parenteral nutrition (TPN)........................................................................ 10-20
- Medication Cartridge ....................................................................................... 5-10
- Dressing change for IV central line (sterile technique) .......................................... 10-15
- Central IV Cap Changes .................................................................................... 3-5
- Port-A-Cath (Access, secure, discontinue) .......................................................... 5-15

## MEDICATION ADMINISTRATION

- Administer oral medication (or meds in food)......................................................... 1-5
- GT/NG/JG medication (single/multiple-administration/flushing - liquid/crushed)........ 3-10
- Administer injectable medication (intramuscular or subcutaneous) ........................... 2-5
- Apply topical medication - per application site (Creams ointments, paste, patches).. 1-3
- Miscellaneous Medications (ear drops, eye drops, nasal spray, inhaler) .................... 1-3
- Insertion of Suppository (Rectal or Vaginal)........................................................... 5-10
- Hang IV medications ......................................................................................... 10-15
- IV Push, Per Medication (range reflects the varying rates per medication)............... 2-10
- Insulin Pump Infusion Set (includes insertion and cartridge prep, change tubing)..... 5-10

## RESPIRATORY CARE

- Oral/Nasal Suctioning ......................................................................................... 2-3
- Tracheostomy – clean tubes and/or change inner cannula..................................... 5-15
- Tracheostomy – dressing change and /or change of ties........................................ 3-10
- Compressed Air/CPAP/BiPAP - apply/remove/settings .......................................... 3-10
- Chest Physiotherapy - percussion and postural drainage (manual)......................... 3-10
- Vest Airway Clearance System (on/off)................................................................ 5-10
- Cough assist machine (cycles) .......................................................................... 10-20
- Apply/remove Tracheostomy Heat/Moisture Plug (Nose) or Talk Valve...................... 1-3
- Nebulizer treatment (load/hold) – consumer unable to hold mouthpiece/mask (time per dose)................................................................................................................ 10-15
- Administer Oxygen, regulate flow, cannula/mask (on/off) ......................................... 1-3
- Ventilators - apply/remove/settings (bedside and/or mobile vent)............................. 1-3
- Inhaler .................................................................. See Medication Administration

## WOUND CARE

- Prep for Wound Care (Gather supplies, Set-up field, Reposition)............................. 1-3
- Remove Old Dressing........................................................................................ 1-5
- Clean Wound ................................................................................................... 1-5
- Apply Treatment (ointments, topical medications, packing, wet-to-dry) ..................... 1-3
- Dressing Application (includes wound drain dressing)............................................. 1-4
- Empty Wound Drain........................................................................................... 3-5
- Apply Barrier Dressing ...................................................................................... 3-5

MISCELLANEOUS

- Finger Stick Blood Testing (glucose, INR, etc.) ........................................ 2-5
- Blood sample from central venous access ........................................ 5-10
- Urine Testing ........................................ 1-2
- Passive range of motion exercises (per session) (Consult LHCP for frequency) ....... 5-30
- Lymphedema Wraps (per limb) (Consult LHCP for frequency) ........................................ 10-30

VITAL SIGNS (WHEN REQUIRED TO SAFELY PERFORM PROCEDURE/TASK)

- Vital Signs (Blood Pressure, Pulse, Respirations, Temperature, Oxygen Saturation) . 2-5
- Body Weight ........................................ 1-3

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Your patient is requesting the following Paramedical Services:

____________________________________________________________

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| ~~PARAMEDICAL SERVICES (EXAMPLES)~~ | ~~NON-PARAMEDICAL SERVICES (EXAMPLES)~~ |
|---|---|
| ~~-Ostomy irrigation/base change, enema or suppository insertion~~<br>~~-Urine catheter, Foley replacement/irrigation~~<br>~~-Injections~~<br>~~-Glucose testing~~<br>~~-G/J Tube: feeding, hydration, medication administration~~<br>~~-Peritoneal/Central line home-dialysis~~<br>~~-Wound cleaning~~ | ~~-Domestic and related services: i.e. meal preparation and cleanup, laundry, grocery shopping, routine maintenance of Respiratory Equipment, etc.~~<br><br>~~-Personal care: i.e. Bathing, bed baths, grooming, oral hygiene, bowel, bladder, and menstrual care, assistance with Prostheses and Medications,~~<br><br>~~-Stand-alone blood pressure and vital sign checks~~ |

If you have any questions about completion of this form, please contact the county Social Worker or Public Health Nurse at the following:

| SOCIAL WORKER NAME or PUBLIC HEALTH NURSE NAME | SIGNATURE<br>▶ |
|---|---|
| TELEPHONE NUMBER | EMAIL |

| PATIENT'S NAME |
|---|
| IHSS CASE NUMBER |

**SECTIONS 1 THROUGH 5 TO BE COMPLETED BY THE RECIPIENT'S PHYSICIAN/SURGEON/D.O., PODIATRIST, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), or DENTIST ~~LHCP~~**

**PLEASE PRINT CLEARLY:**

**1.**

| NAME ~~OF LHCP~~ | |
|---|---|
| OFFICE TELEPHONE NUMBER | MEDICAL LICENSE NO./MEDI-CAL PROVIDER NO. |
| OFFICE ADDRESS | |
| TYPE OF PRACTICE/MEDICAL SPECIALTY | |
| MEDICAL TITLE<br>☐PHYSICIAN/SURGEON/D.O. ☐PODIATRIST ☐PHYSICIAN ASSISTANT (PA) ☐NURSE PRACTITIONER (NP) ☐DENTIST | |

**2. DOES THE PATIENT HAVE A MENTAL OR PHYSICAL FUNCTIONAL LIMITATION WHICH RESULTS IN A NEED FOR ASSISTANCE BY AN IHSS PROVIDER FOR PARAMEDICAL SERVICES? ☐YES ☐NO**

If YES, describe ~~list~~ the functional limitation(s) below:

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**3. LIST THE PARAMEDICAL SERVICES WHICH ARE NEEDED AND SHOULD BE PROVIDED BY AN IHSS PROVIDER**

*If the time required to perform the paramedical service exceeds the time range provided in the attached Paramedical Services Authorization Reference Tool ~~for this patient falls outside of the attached Statewide Paramedical Services Time Guidelines~~ due to the patient's specific needs ~~circumstances~~, you must describe how the recipient's functional limitation necessitates ~~provide justification for~~ the time ordered in ~~the following section (~~section 4~~)~~. You may attach separate pages if needed.

~~Example: Listing Paramedical Services~~

| ~~Type of Service~~ | ~~Time required to perform the service~~ | ~~Frequency~~ | | ~~How long should this service be provided~~ |
|---|---|---|---|---|
| ~~Injection (insulin or other)~~ | ~~5 minutes~~ | ~~3 times~~ | ~~Daily~~ | ~~Continued~~ |

| TYPE OF PARAMEDICAL SERVICE | *TIME (IN MINUTES) REQUIRED TO PERFORM THE PARAMEDICAL SERVICE | FREQUENCY AND NUMBER OF TIMES PERFORMED (DAILY, WEEKLY, ETC.) | HOW LONG DOES THIS SERVICE NEED TO BE PROVIDED? (Specify Begin Date and ~~ongoing or provide an~~ End Date) |
|---|---|---|---|
| ***EXAMPLE ONLY:*** *Injection (insulin or other)* | *5 minutes* | *3 Times Daily* | *3/5/2018 - Continuous* |
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**4. DESCRIBE HOW THE RECIPIENT'S FUNCTIONAL LIMITATION NECESSITATES THE NEED TO AUTHORIZE ~~ADDITIONAL COMMENTS TO EXPLAIN~~ TIME ABOVE ~~OUTSIDE OF~~ THE TIME RANGE IN THE PARAMEDICAL SERVICES AUTHORIZATION REFERENCE TOOL ~~STATEWIDE PARAMEDICAL SERVICES TIME GUIDELINES~~ (IF APPLICIBLE)**

☐ Please check here if separate pages are attached.

**5. PLEASE LIST IHSS PROVIDER(S) TRAINED TO PERFORM THIS/THESE PROCEDURE(S).**

☐ Please check here if the IHSS provider was not trained by you or your staff. ~~is not at this appointment.~~ He/she must complete the SOC 321A when he/she has received training directed by a LHCP licensed pursuant to Division 2 of the Business and Professions Code to certify that he/she is able to perform the Paramedical Services.

| IHSS PROVIDER(S) NAME | TRAINING PROVIDED BY (INCLUDE TITLE) | TYPE OF PARAMEDICAL SERVICE TRAINED ON | DATE OF TRAINING |
|---|---|---|---|
| | | | |
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**~~LHCP~~ CERTIFICATION**

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgment the paramedical services which I have ordered are necessary to maintain the patient's health and would normally be performed by the recipient for himself/herself if not for his/her functional limitation(s).

I shall provide such direction as needed, in my judgment, in the provision of the ordered paramedical services. I have informed the patient of the risks associated with the provision of the ordered paramedical services.

| ~~LHCP~~ SIGNATURE ▶ | DATE |
|---|---|

| PATIENT'S NAME |
| --- |
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## IHSS RECIPIENT'S INFORMED CONSENT

***Social Worker may have recipient complete informed consent ~~prior to~~ after the LHCP has completeding the SOC 321 and certified that they have informed the patient of the risks associated with the provision of the ordered paramedical services.**

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I the undersigned have been advised of risks associated with the provision of the paramedical services listed above and consent to the provision of these services by my IHSS provider(s).

I accept the responsibility for allowing this person named on the SOC 321 and/or 321A form to perform these paramedical services and I understand the County and the State of California are immune from any related liability.

I agree to inform the County Department of Social Services if there are any changes in my condition that changes my need for paramedical services.

I agree to have a new SOC 321 completed if I have a need for new paramedical service(s).

I agree to notify the county within 10 calendar days if my provider(s) of these paramedical services changes. This includes when a new provider will be performing my paramedical services or my existing provider quits or is fired.

I agree to inform my IHSS provider(s) of my existing paramedical service needs and inform him/her that he/she must get the necessary training in order to properly perform these services for me and get paid for performing these services.

I THE UNDERSIGNED DECLARE UNDER PENALTY OF PERJURY THAT THE FORGOING STATEMENTS ARE TRUE AND CORRECT.

| IHSS RECIPIENT'S SIGNATURE ▶ | DATE |
| --- | --- |
| AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF) | |
| RELATIONSHIP TO RECIPIENT | TELEPHONE NUMBER |
| SIGNATURE | DATE |

**Return to: (County Social Services/IHSS Department)**

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