PHYSICIAN'S RECOMMENDATION FOR NURSING SERVICES AT HOME

Member/Employee Statement

Name of Member/Employee:	Name of Patient:
Group Number:	Relationship:
Certificate Number:	Patient Date of Birth:
Name and Address of Attending Physician:	

Attending Physician's Statement

In order that we may properly assess the Plan's liability for nursing services being claimed by the above name patient, we require the following information completed in full:

1. Diagnosis:
2. Recommended level of expertise: RN ☐ RNA ☐ VON ☐ LPN ☐
3. If the patient is receiving medications, please specify the drug name, dosage, frequency and method of administration:
4. Other than the administration of drugs, please provide a description of all other required functions for the care of the patient:
5. Please provide the expected duration for which nursing services will be required:
6. In addition, please provide the following:

   Number of hour(s) per Day:

   Number of day(s) per Week:
7. Please provide any additional information including prognosis:
8. Please attach an estimate for nursing services to this form.
9. Please attach a copy of the approval or denial of Provincial Plan coverage.

Physician's Signature: ____________________________________

Date: ____________________________________