NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Private Duty Nursing (PDN) Referral Form – DHB-3508

Instructions: The form below must be completed in its entirety for consideration of Private Duty Nursing (PDN) services. If a section does not apply to the referral, please enter N/A.

Type of Request	
☐ Initial referral to PDN ☐ Transfer of care from another agency	
Beneficiary Information	
Name:	
Address:	
Phone #:	Gender:
MID #:	Birthdate:
Providing Agency Information	
PDN Provider Agency Name:	
Address:	Provider Agency Contact Name and Title:
Phone #:	NPI #:
Trained Caregiver Information	
Name:	Relationship to beneficiary:
Address:	Phone #:
Employed or attending college courses? ☐ Yes ☐ No If employed, please detail work hours below: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____ Number of weekly hours worked (or average weekly hours): _____ *Note: If attending college courses, please include a recent copy of caregiver's class schedule.*	
COMMENT:	
Trained Caregiver Information	
Name:	Relationship to beneficiary:

Private Duty Nursing (PDN) Referral Form – DHB-3508

Address:	Phone #:
Employed or attending college courses? ☐ Yes ☐ No If employed, please detail work hours below: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____ Number of weekly hours worked (or average weekly hours): _____ *Note: If attending college courses, please include a recent copy of caregiver's class schedule.*	
COMMENT:	
Attending Physician Information	
Attending physician:	Phone #:
Address:	Date of last attending physician assessment:
Prognosis:	Estimated length of time PDN services required:
Active diagnosis(es) that support the need for PDN:	
Projected hospital discharge date/start of care:	
Weekly Hours requested:	
Private Insurance Information	
Does this beneficiary have insurance in addition to Medicaid? ☐ Yes ☐ No	
Is PDN covered by private insurance? ☐ Yes ☐ No	
If Yes, please detail the insurance company name, # of hours/week covered and the dates of coverage: *Note: If private insurance covers any portion of PDN services, an Explanation of Benefits document must be submitted with the PDN referral.*	
COMMENT:	

Private Duty Nursing (PDN) Referral Form – DHB-3508

School Information
Does this beneficiary (between the age of 3 and 20) attend school? ☐ Yes ☐ No ☐ N/A If Yes, please complete the fields below.
Name of school: School district:
What is the typical school schedule? Start: _____ End: _____ How many days per week? _____ Number of weekly hours contracted: _____ *Note: Please include transportation time if a nurse must accompany beneficiary.*
What type of support does the beneficiary have in school? ☐ None ☐ 1:1 support staff ☐ School nurse ☐ Skilled nurse
If skilled nursing support is provided, are the hours billed to NC Medicaid by the LEA via school contract? ☐ Yes ☐ No If No, please specify why:
Medical Information
Ventilator dependency? ☐ Yes ☐ No If Yes, what type of ventilator?
How many hours per day is the beneficiary dependent on the ventilator? ☐ 24 hours/day ☐ 8-23 hours per day ☐ less than 8 hours per day or PRN
Tracheostomy requiring suctioning? ☐ Yes ☐ No If Yes, how often is tracheal suctioning completed? ☐ Q 1 hour or more frequently ☐ Q 2-4 hours ☐ Q 5 hours or less frequently How often is routine tracheostomy care completed?
Oxygen dependency? ☐ Yes ☐ No If Yes, please choose one: ☐ Continuous (eight hours or more per day) ☐ Intermittent with pulse ox at least every shift

Private Duty Nursing (PDN) Referral Form – DHB-3508

Specify orders for oxygen needs below:

Scheduled nebulizers/cough assist device/chest physiotherapy?

☐ Yes ☐ No

Specify orders for nebulizers, cough assist devices and/or chest physiotherapy below:

Medications to be managed and administered must be listed below and/or a medication list must be submitted with this request:

**Note: please include medication names, dosages, frequencies and routes administered.*

G/J Tube? ☐ Yes ☐ No

If Yes, please choose the appropriate option below:

- ☐ Continuous (eight hours or more)
- ☐ Bolus feeds
- ☐ Continuous AND bolus feeds

Specify enteral feed name, dosage and frequency below:

Private Duty Nursing (PDN) Referral Form – DHB-3508

TPN? ☐ Yes ☐ No If Yes, please specify the frequency and duration below:

Please detail any other skilled nursing interventions and the frequency with which these are completed.

Attending Physician Attestation
I am requesting Private Duty Nursing services for the above-named beneficiary due to his/her current medical condition.
Attending physician signature:
Date:
"I hereby attest that the information contained herein is current, complete and accurate to the best of my knowledge and belief."