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| Transforming Lives | | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  **Nurse Delegation Referral and Communication** | | | | | | | | | | |
| **Case / Resource Manager’s Request** | | | | | | | | | | | | |
| 1. OFFICE  HCS  AAA  DDA  Other | | | | | | 2. AUTHORIZATION NUMBER FOR  NURSE DELEGATION | | | | 3. RN PROVIDERONE ID | | |
| 4. DATE OF REFERRAL | | | 5. METHOD OF REFERRAL  E-mail  Telephone  Fax | | | | | | | | | |
| **TO:** | 6. NURSE DELEGATOR / AGENCY | | | | | | | | | | | |
| 7. TELEPHONE NUMBER | | | | 8. FAX NUMBER | | | | 9. EMAIL ADDRESS | | | |
| **FROM:** | 10. C/RM NAME / OFFICE | | | | | | | | 11. EMAIL ADDRESS | | | |
| 12. TELEPHONE NUMBER | | | | | | | | 13. FAX NUMBER | | | |
| 14. REQUIRED ATTACHMENTS (IF APPLICABLE)  CARE / DDA Assessment  PCSP / DDA  PBSP  Service Summary Plan  Consent (DSHS [14-012](http://forms.dshs.wa.lcl/)) | | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | |
| 15. CLIENT’S NAME | | | | | | | 16. GUARDIAN’S NAME | | | | 17. ACES ID | |
| 18. CLIENT’S DATE OF BIRTH | | | | | | | | 19. TELEPHONE NUMBER | | | | |
| 20. ADDRESS CITY STATE ZIP CODE | | | | | | | | | | | | |
| 21. LONG TERM CARE WORKER(S) AND/OR RESIDENTIAL PROVIDER’S NAME | | | | | | | | | | | | |
| 22. TELEPHONE NUMBER | | | | 23. FAX NUMBER | | | | 24. CLIENT’S / GUARDIAN’S EMAIL ADDRESS | | | | |
| 25. CLIENT COMMUNICATION  This client needs an interpreter  Primary language needed is:  Deaf / HOH | | | | | | | | | | | | |
| 26. PRIMARY DIAGNOSIS RELATED TO DELEGATION | | | | | | | | | | | | |
| 27. REASON FOR RND REFERRAL | | | | | | | | | | | | |
| **Communicating with RND** | | | | | | | | | | | | |
| **C/RM will OPEN Nurse Delegation Authorization prior to sending referral.**  **C/RM may cancel authorization if form is not returned by RND.** | | | | | | | | | | | | |
| 28. CASE/RESOURCE MANAGER’S SIGNATURE | | | | | | | | | | | | 29. DATE |

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| **30. Confirmation of Receipt of Referral and Response by Registered Nurse Delegator agency** | | |
| DATE RECEIVED | Referral accepted  Referral not accepted  Nurse assigned: | |
| PRINTED NAME |
| Additional comments: | | |
| SIGNATURE | TELEPHONE NUMBER | EMAIL ADDRESS |

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| Transforming Lives | | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  **Nurse Delegation Referral and Communication** | | | | |
| **Delegating Nurse’s Response** | | | | | | |
| **TO:** | 31. C/RM NAME | | | 32. EMAIL ADDRESS | | |
|  | 33. TELEPHONE NUMBER | | | 34. FAX NUMBER | | |
| **FROM:** | 35. RND NAME | | 36. PROVIDERONE ID | | 37. EMAIL ADDRESS | |
|  | 38. TELEPHONE NUMBER | | | 39. FAX NUMBER | | |
| **RE:** | 40. CLIENT’S NAME | | | | | |
| 41. Nurse delegation has been started  Yes  No | | | | | | 42. ASSESSMENT DATE |
| **Follow Up Information** | | | | | | |
| 43. List the tasks that were delegated: | | | | | | |

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| 44.  Nurse Delegation was not implemented. Indicate the reason and any other action taken: |

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| 45.  RND suggests these other options for care: |

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| 46. RND ADDITIONAL COMMENTS | |
| 47. NURSE DELEGATOR’S SIGNATURE | 48. DATE |

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| **Instructions for Completing Nurse Delegation: Referral and Communication Case/Resource Manager’s Request**  1. Office: Identify office making the referral.  2. Authorization Number for Nurse Delegation: Enter authorization number for referral.  3. RN ProviderOne ID: Enter the agency or nurse delegator ProviderOne ID.  4. Date of Referral: Enter date the referral is being sent to agency or nurse delegator.  5. Method of Referral: Identify if referral was made via E-mail, Telephone, or Fax.  6. Nurse Delegator / Agency: Enter name of agency or nurse delegator that the referral is being sent to.  7. Telephone Number: Enter telephone number of agency or nurse delegator.  8. Fax Number: Enter fax number of agency or nurse delegator.  9. Email Address: Enter the email address of agency or nurse delegator.  10. C/RM Name / Office: Enter name of person making the referral and location.  11. E-Mail Address: Enter email address of C/RM making referral.  12. Telephone number: Enter telephone number of C/RM making the referral.  13. Fax number: Enter fax number of C/RM making the referral.  14. Required Attachments (if applicable): Enter the documents that will be attached to referral form.  15. Client’s Name: Enter ND client’s name (last name, first name).  16. Guardian’s Name: Enter the guardian’s name (last name, first name).  17. ACES ID Number: Enter the client’s ACES ID number.  18. Client’s Date of Birth: Enter the client’s date of birth.  19. Telephone Number: Enter client’s / guardian’s telephone number.  20. Address: Enter client’s physical street address, city, state, and zip code.  21. Long Term Care Worker(s) and/or Residential Provider’s Name: Enter long-term care worker (LTCW) or Residential Provider.  22. Telephone Number: Enter LTCW or AFH telephone number.  23. Fax Number: Enter LTCW or AFH fax number.  24. Email Address: Enter client’s / guardian’s email address.  25. Client Communication: Identify if client will need interpreter services and what language requested.  26. Primary Diagnosis Related to Delegation: Enter the client primary diagnosis related to Nurse Delegation request.  27. Reason for RND Referral: Enter the reason for Nurse Delegation referral.  28. C/RM’s signature.  29. C/RM’s date of signature.  **Nurse Delegator completes 30 through 48:**  30. Confirmation of Receipt of Referral and Response by Registered Nurse Delegator Agency. Nurse Delegator’s response to referral.  31. C/RM Name: Enter Case Manager / Case Resource Managers name.  32. Email Address: List Case Manager / Case Resource Managers email address.  33. Telephone Number: Enter Case Manager / Case Resource Managers telephone number.  34. Fax Number: Enter Case Manager / Resource Managers fax number.  35. RND Name: List name of Nurse Delegator completing form.  36. ProviderOne ID: Enter RND’s ProviderOne ID.  37. Email Address: List RND’s email address.  38. Telephone Number: Enter RND’s telephone number.  39. Fax Number: Enter RND’s Fax number.  40. Client’s Name: Enter client’s name.  41. Identify if delegation has started by checking “Yes” or “No.”  42. Assessment Date: Enter date of Nurse Delegation assessment.  43. List tasks which were delegated to LTCW(s).  44. Check box if Nurse Delegation was not implemented. Indicate the reason and any other action taken.  45. Check box if RND suggest other options for care. Indicate suggested options for care.  46. Enter any additional RND comments.  47. Nurse Delegate’s signature.  48. Enter date of completion. |