LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Revised 5/25/2022

ACT 421 – CHILDREN'S MEDICAID OPTION (TEFRA)

HEALTH RECORD REQUEST FORM

Name of Child: _____

Name of Parent/Legal Guardian: _____

Contact Phone Number: _____

Please submit supporting documentation and provider information for all reported diagnoses/treatments. If you have any questions about this form, please reach out to your Local Governing Entity (LGE). If you need more space use question 11 or attach additional pages.

DIAGNOSIS INFORMATION

1. What are the child's current diagnoses?

Diagnosis	**Name/Title of Person Who Made the Diagnosis**	**Date of Diagnosis** *(mm/dd/yyyy)*

2. Communication and Understanding – List any speech/language testing the child has participated in:

Test Name		
Date of Test *(mm/dd/yyyy)*		
Expressive Language Score *(if not known or available, leave blank)*		
Receptive Language Score *(if not known or available, leave blank)*		
Name of Person Giving Test		
Address of Person Giving Test		

3. Learning and Comprehension – List any intelligence testing the child has participated in:

Test Name		
Date of Test *(mm/dd/yyyy)*		
Full Scale IQ		
Name of Person Giving Test		
Address of Person Giving Test		

4. Providers – List all current providers (physicians, home health, social service, etc.) and their contact information (you can sign an *Authorization to Release or Obtain Health Information Form (HIPAA 202L)* to authorize LDH to obtain necessary medical records directly from providers):

Name of Provider	Address	Phone Number	Specialization

5. Therapy – List any therapies (occupational, physical, speech, etc.) in which the child participates:

Name of Provider			
Address			
Phone Number			
Type of Therapy			
Place of Therapy *(school, home, clinic, etc.)*			
Number of Sessions *(per week)*			

6. Hospitalizations – Has the child been in the hospital in the past two years? ☐ Yes ☐ No
If yes, please provide the following information:

Name of Hospital			
Address of Hospital			
Reason for Admission			
Date of Admission *(mm/dd/yyyy)*			
Date of Discharge *(mm/dd/yyyy)*			

7. Current Medications – list all prescription medications (including chemotherapy) the child routinely takes:

Name of Medication	How Often	How Taken	Side Effects

8. Current Medical/Nursing Care Needs – please indicate the child's current care needs, how often they are required, their start date, and amount of help the child needs or if the child is independent with needed care:

Care Needed		How Often	Start Date *(mm/dd/yyyy)*	Amount of Help Needed
☐	Apnea monitor			
☐	Nebulizer			
☐	Oxygen			
☐	Suction			
☐	Tracheostomy care			
☐	Ventilator			
☐	IV line indwelling			
☐	Total Parenteral Nutrition (TPN)			
☐	Bowel program			
☐	Dialysis			
☐	Ostomy care			
☐	Tube feeding			
☐	Urinary catheter care			
☐	Other:			
☐	Other:			
☐	Other:			

9. School – Does the child have an Individualized Education Program (IEP)? ☐ Yes ☐ No
Is the child enrolled in special education? ☐ Yes ☐ No
If yes to either of these questions, please provide the following information:

Name of School			
Grade Level			
Name of Teacher			
Address			
Phone Number			

10. If you have any of the following for your child, please indicate below and attach to this application:

	Assessment/Document	Date of Completion *(mm/dd/yyyy)*	Name/Title of Person Who Completed Document
☐	Individualized Education Plan (IEP)		
☐	Inventory for Client and Agency Planning		
☐	Individualized Family Services Plan (IFSP) with the Battelle Development Inventory (BDI)		
☐	Ages & Stages Questionnaire		

11. If you have any additional pertinent information, please include it below:

Form Completed by:

Signature

Print Name

Date *(dd/mm/yyyy)*