Virginia Birth-Related Neurological Injury Compensation Program
Patient Nursing and Caregiver Form

Patient Name:
Claimant ID:

Date of Birth:

The amount and level of care must be substantiated by "medically necessary treatment": 24/hr. coverage and RN's are allowed ONLY for acute or severe cases, i.e. vent. dependent or tracheostomy.(24 hr. care receives Consultant review- submit doc.)

SELECT ONLY ONE LEVEL OF CAREGIVER.

- **Personal Care Aide:** Changing, dressing, bathing, feeding by mouth P.O. foods

  # hours per day _____ or week _____ Duration _____

- **CNA:** Oral feedings (**no meds**), changing, dressing, bathing, etc.

  # hours per day _____ or week _____ Duration _____

- **LPN:** **Please indicate which apply and provide additional info where requested.**
  __ Ventilator (type) continuous or intermittent _____
  __ Trach
  __ C-PAP, BIPAP
  __ Oxygen PRN or continuous @____L/min.
  __ Suctioning – frequency _____
  __ Medication **(simple, moderate, complex) number & route** _____
  _____
  __ Intermittent Cath (frequency) _____
  __ Wound care- location
  __ Trach care
  __ Number of hospitalizations in past year _____
  __ Special treatments (please specify) _____
  __ G-tube feedings :

  # hours per day _____ or week _____ Duration _____

- **RN:** **Only for vent. (continuous) dependent, or trach. patients. (Submit doc.)**

  Specify reason: _____

  # hours per day _____ or week _____ Duration _____

MD Name: _____

MD Signature: _____ Date: _____

Contact Phone: _____ Fax: _____

Please return to: Virginia Birth-Injury Program
7501 Boulders View Drive, Suite 210
Richmond, Virginia 23225

Phone: 804-330-2471
Fax: 804-330-3054