SPECIALIZED PROCEDURES REQUEST COVER SHEET

DS 1851 (New 8/2004) Electronic Version

Please send this cover sheet with your request for approval of Specialized Procedures.
Please use one sheet per procedure.

DATE _____

FACILITY NAME _____

CORPORATION _____

RN/INSTRUCTOR _____

REGIONAL CENTER _____

TEACHING METHOD: (select one)

- ○ Lecture
- ○ Lecture/Video
- ○ Lecture/Literature
- ○ Other: _____

TOPIC: (select one)

- ○ Apnea monitoring
- ○ Colostomy care
- ○ Gastrostomy feeding and care
- ○ Medication administration via a gastrostomy tube
- ○ Tracheostomy care and light suctioning
- ○ Oxygen therapy
- ○ Intermittent positive-pressure breathing
- ○ Catheterization - clean technique
- ○ Wound care - simple dressing changes
- ○ Other: _____

DESIGNATED FACILITY REPRESENTATIVE _____

PHONE _____

FAX _____

DDS APPROVAL _____

DATE _____