

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

TEACHING METHOD: (select one)

REGIONAL CENTER

- 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