Comagine Health

Nurse (RN) Delegation

Form CH-011

Nurse (RN) delegation(s) are to be submitted to Comagine Health for individuals who require additional supportive services to assist with their ongoing care. RN delegations are to be submitted every 6 months in alignment with the RN reassessments or more frequently if applicable. Plan of Care (POC) authorizations will be entered according to expiration dates of RN delegations up to 3 month increments for PRN delegations or 6-month increments for all other delegations. RN delegated tasks have an LSI score (Residential LSI line #7 and AFH LSI line #5). Updated documentation must be submitted to Comagine Health for each POC entry. A separate RN delegation must be completed for each staff member completing the delegated task (OAR 851-047-0000 - 851-047-0060).

I. RN Delegation Details

Individual Name:

Individual Date of Birth:

Individual Medicaid ID Number:

Provider Name:

Nurse Name:

Nurse Licensing Number:

Nurse Contact Number:

Delegated Staff Completing Task:

Date of Delegation:

Date Delegated Staff Trained (within 6 months):

Date of Next Review (no longer than 6 months from date of last training):

Please provide comprehensive answers to the questions below according to the Oregon State Board of Nursing Interpretive Statement pertaining to the delegated task.
Oregon Secretary of State Administrative Rules

1. What task is being delegated?

2. Reason and condition requiring delegation

3. Is any portion of the delegated task completed by the individual? Please provide specific details.

4. Frequency of the delegated task

   ☐ Daily

   ☐ Weekly

   ☐ Monthly

   ☐ Other (please describe):

II. Required Documentation

☐ CH-011 RN Delegation Form

☐ RN Delegation (must have legible RN signature and printed name, legible name of client, legible name of delegated staff, staff signature and an identified 6-month follow-up date)

☐ Medication Administration Record (MAR) / past 90 days or since admission (must have legible signatures and printed names)

☐ Training Log (if applicable)

☐ Signature Log (if not included on MAR)

☐ Physician Order (if applicable)

☐ Other (as needed):

III. Signatures

RN Name: _____

Signature: _____ Date: _____

Delegated Staff Name: _____ Title _____

Signature: _____ Date: _____

Save as Print Clear form