ACUTE INPATIENT REHAB REQUEST

**Please complete all areas of this survey.

FAX: **1-800-416-9195**

Please review all eight parts to this form and fill in the applicable sections

- Part One – Patient Information
- Part Two – Prior Level of Function
- Part Three – Clinical Review
- Part Four – Physical Therapy
- Part Five – Occupational Therapy
- Part Six – Speech Therapy
- Part Seven – Discharge Plan
- Part Eight – Protected Health Information (PHI)

DATE FORM COMPLETED	ADMISSION DATE TO POST ACUTE FACILITY

Part One – Patient Information

Demographic information	Responses
Member Name:	
DOB:	
Member ID#:	
Reference/case number:	
SNF Facility name:	
Facility NPI:	
Facility address, city, state, zip:	
Contact name/department:	
Contact phone number and fax number:	
Accepting MD name and NPI:	
MD phone number:	
MD address, city, state, zip:	

Transfer Information	Responses
Transfer from:	
What was the date of admission in the acute care:	
Is the date of injury or illness within the last 30 days of this request: (yes/no)	
Name/phone # of contact at transferring facility:	
Diagnosis for post acute admission: (include ICD code)	
Reason for skilled stay: (Does the medical complexity require frequent medical assessment, intense monitoring with a potential for rapid deterioration or debility makes care at home unsafe?)	
****Can the member tolerate one hour of therapy 5 days a week with full participation: (yes/no)**	
Chronic conditions:	

PART TWO – PRIOR LEVEL OF FUNCTION

Question:	Answer:
Does the member ambulate?	O Yes O No
Does the member have gait limitations? (If yes specify limitation and assistance required)	O Yes O No Limitations and Assistance Required: _____
Does patient use wheelchair?	O Yes O No
What is the patient's transfer level of assistance?	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
What assistance does the patient need with daily living activities>	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
Does member have DME at home?	O Yes O No If Yes, please specify: _____
Does the patient have community or other resources already in place?	O Meals on Wheels OHHC O Caregivers O Other: _____
What is the patient's baseline mental status?	
Does the member have any cognitive issues such as communication difficulty, memory deficits, or perception or processing deficits?	O Yes O No Specify: _____

Question:	Answer:
Does the member have any physical inability or limitations such as wound location unreachable, contractures, obesity, motor strength, comorbidity such as blindness or paralysis?	O Yes O No Specify: _____
Is the home environment not conducive to care such as no running water, no phone, no temperature control, no elevator, no access to home care agency or outpatient services, any physical or emotional abuse at home?	O Yes O No Specify: _____
Does the patient need home oxygen? If yes, specify.	O Yes O No Specify: _____

Home set up	Responses
# steps to enter home:	
Stair Rails: (yes/no)	O Yes O No
Bed on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Bath on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Availability for first floor setup: (yes/no)	O Yes O No
Who does the member live with currently: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	O Home Alone O Personal Care Home O Caregiver/family/significant Other O Assisted Living Facility O Long Term Residential Care O Other: _____

PART THREE – CLINICAL REVIEW

Clinical Reviews must be submitted within 48 hours of requested Admission Date.

Continued Stay Requests must be requested within 24 hours from the last covered day.

Information	Answers/Responses
Date:	
Vitals:	
Mental status/Able to follow commands:	O Yes O No
Abnormal Labs (if being monitored or treated):	O Yes O No Specify: _____
Will member receive IV medications: If yes name, frequency and stop date.	O Yes O No Name: _____ Frequency: _____ Stop Date: _____
Respiratory: include o2 flow, teaching needs, o2 sats, nebulizers and how often, trach (date placed, size, suctioning frequency) What is the goal: decannulation, home with trach, home oxygen, wean off oxygen, home nebs.	O2 Flow: _____ Teaching Needs: _____ O2 Sats: _____ Nebulizers: _____ Goal: _____
Oral diet	O Yes O No Specify: _____
NG/Peg: (include date placed, what feeds receiving, rate, goal rate, are they tolerating)	Date Placed: _____ Feeds Receiving: _____ Rate: _____ Goal Rate: _____ Tolerating: O Yes O No

Information	Answers/Responses
TPN: (yes/no) if yes stop date, rate, were they on TPN at home	O Yes O No Stop Date: _____ Rate: _____ TPN at Home: O Yes O No
Wounds/treatment: (include stage, tx, measurements, frequency dressing, appointment with wound specialist.)	

PART FOUR - PHYSICAL THERAPY

Clinical Reviews must be submitted within 48 hours of requested Admission Date.

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

Category:	As of date:	Independent	Modified Independent	Supervision	Contact Guard Assistance	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Bed mobility									
Rolling side to side									
Supine to sit									
Sit to stand									
Bed to chair									
Sitting balance static/dynamic									
Standing balance static/dynamic									
Steps with number of steps included									
Gait assistance									
Gait distance in steps/feet: _____ Assistive device used: _____									

Category:	As of date:	independent	modified independent	supervision	contact guard assistance	minimal assistance	moderate assistance	maximum assistance	dependent
Wheelchair assistance									
Wheelchair distance: _____									
Endurance: _____									
Strength: _____									
PT Goals-Short term and Long term: _____									

PART FIVE – OCCUPATIONAL THERAPY

Clinical Reviews must be submitted within 48 hours of requested Admission Date.

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

Category	As of date	Independent	Modified Independent	Supervision	Contact Guard Assistance	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
feeding									
grooming									
Bathing UE									
Bathing LE									
Dressing UE									
Dressing LE									
Toileting/ hygiene									
Toilet/ functional transfer									
Household management									
OT Goals: Short term _____ Long term _____									

PART SIX - SPEECH THERAPY

Clinical Reviews must be submitted within 48 hours of requested Admission Date.

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

As of date:	Responses
Cognition: (alert and oriented, can member follow commands)	
Language deficit: can they express needs?	O Yes O No
Memory deficits:	
Safety judgement/problem solving: (are they impulsive, require a sitter)	
Swallowing deficits:	O Yes O No
What type of diet/liquids:	
Goals: Short term and long term:	Short Term: _____ Long Term: _____

PART SEVEN - DISCHARGE PLAN

Items to Complete	What's Been Completed
Has Caregiver Training been completed? Any barriers to Caregiver Training?	
Anticipated disposition: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	
Caregiver available to assist: (yes/no) include hours available to assist, If no please specify.	
Are there any social determinates: (social connections, transportation needs, safety, financial resource strain, health literacy, housing stability, food insecurity)	
DME needs: (if yes, please specify)	
Is a home evaluation planned/needed prior to discharge: (yes/no)	
Will the member require home health care, outpt therapy, other -please explain:	
Community resources needed: (if yes, what)	
Next MD appointment:	
Any additional pertinent information or other discharge barriers:	

PART EIGHT – PROTECTED HEALTH INFOMRATION (PHI)

These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call the facility phone number listed in the demographic area above.

Providers are required to return, destroy, or further protect any PHI you receive pertaining to a patient that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

9/17/2021