Clinical and therapy request form

Update due weekly:

- **Initial reviews:** Please send face sheet, admit orders, initial therapy evaluations and clinical and therapy request form including the first week's progress. Attach additional clinical information as needed.
- **Concurrent reviews:** Please complete this form. Attach additional clinical information as needed.
- **Upon discharge:** Please send the Discharge (D/C) medication list, name of Home Health Care (HHC) agency and follow-up (F/U) community PCP appointment date and time

Facility name:							
Facility contact name & title/email:							
Facility fax/phone number:							
Member name:				**DOB:**			
Admit date/authorization number/service reference number (SRN):							
Community PCP – name & phone number:							
Pharmacy name and phone:							
Advance directives? Y/N & type, e.g., POA, living will, HCS, DNR:							
Primary diagnosis:							
Past medical history, if H&P not attached:							
Prior level of functioning (PLOF):							
Home setting – e.g., Single level, apartment w/elevator, mobile home w/stairs:							
Number of stairs in prior living environment?							
Weight-bearing restrictions:				**F/U ortho or surgical appt. date:**			
LEVELS	**(7 Comp I)**	**(6 Mod I)**	**(5 Supervision/SBA)**	**(4 Min A/CGA)**	**(3 Mod A)**	**(2 Max A)**	**(1 Total A)**

OCCUPATIONAL THERAPY (Daily notes not needed)	Update_____	Update_____	Update_____	Update_____	Update_____
Feeding					
Grooming					
Bathing					
Dressing – upper body					
Dressing – lower body					
Toileting/hygiene					
Transfer – toilet					
Transfer – tub/shower					
PHYSICAL THERAPY (Daily notes not needed)	Update_____	Update_____	Update_____	Update_____	Update_____
Bed mobility					
Transfer – chair/WC					

Member name:		DOB:			
PHYSICAL THERAPY (cont) (Daily notes not needed)	Update_____	Update_____	Update_____	Update_____	Update_____
Gait - distances/assist					
Assistive device? Y/N & type					
Number of stairs currently & assistance needed?					
Wheelchair mobility					
Home evaluation needed? Y/N & date scheduled					
SPEECH THERAPY (Please attach notes)					
Diet – Liquid, mech. soft, puree, regular, enteral					
Cognition/level of orientation, e.g., confused, A&O x 3:					
Describe deficits r/t memory, problem solving, safety awareness:					
NURSING					
IV/SQ Meds - Name, Frequency & Stop Date:					
Respiratory needs – O2, trach, vent, suctioning, nebs, Bi or C-Pap:					
Wound care: *Attach wound notes – including location, stage, description, dimensions and treatment*					
Pain level, location & treatment:					
Misc./other daily skilled nursing needs:					
DISCHARGE PLANNING					
D/C Plan:					
Psychosocial issues:					
Anticipated D/C date:		Flu vaccine? Y/N		Pneumonia vaccine? Y/N	
Barriers to D/C plan:					
New DME needed at D/C?					
Is there a caregiver? Y/N		Days/week:		Hours/day:	
What type of caregiver education was provided?					
POA/responsible party? Y/N, if yes, include name & contact number					

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