Skilled nursing facility 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 primary care provider (PCP) appointment date and time

Member name:	Date of birth:
Admit date/authorization number/service reference number (SRN):	
Facility name:	
Facility contact name and title/email:	
Facility fax/phone number:	
Community PCP – name and phone number:	
Pharmacy name and phone:	
Advance directives? Y N and 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:

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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
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
Bed mobility				
Transfer – chair/WC				
Gait – distances/assist				
Assistive device? Y/N and type	Y N	Y N	Y N	Y N
Number of stairs currently and assistance needed?				
Wheelchair mobility				
Home evaluation needed? Y/N and date scheduled	Y N	Y N	Y N	Y N

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Speech therapy (please attach notes)

	Update	Update	Update	Update
Diet – liquid, mechanical 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 and 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 and 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 and contact number):

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