SNF INITIAL REVIEW

Please fax completed form to your facility's assigned IEHP Nurse.
All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

Name *(Last, First, M.I.):*	**DOB:**	**Auth #**	**Admission Date:**
Facility:		**Attending:**	
Admit Dx:		**Height:**	**Weight:**
Co-Morbidities:			
Admit Level of Care:	☐ Sub acute ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Custodial		
Justification for Level:			
DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo		#hrs/month:	
Current Barriers to DCP:			
Treatment Goals:			
Prior Living Conditions:			
Prior Level of Function:			
Does Member have social or family support? ☐ Yes ☐ No **Describe:**			
Does Member own DME? ☐ Yes ☐ No **Type?**			
Does Member have income? ☐ Yes ☐ No **How much per month?**			
Does Member Have an Advance Directive or Living Will? ☐ Yes ☐ No	**DPOA:**	**Phone Number:**	
Does SNF Facility Provide Transportation? ☐ Yes ☐ No ☐ Other:			
Indicate Transportation Needs: ☐ O_2 ☐ Cane ☐ Gurney ☐ Wheelchair			
Does Member have the potential to go back home when ready for discharge? ☐ Yes ☐ No **If No, Why?**			

PATIENT SUPPORT/CAREGIVER

Name *(Last, First, M.I.):*		**Relationship:**
Address:		**Email:**
Party to Sign Contract:		
Home Number:	**Cell Number:**	**Work Number:**

PERSONAL SAFETY & ACTIVITY LEVEL

Resident Care Needs *(Check all conditions that apply):*
Dietary Requirements/Restrictions:

☐ Chemo	☐ Eloper/ Wanderer	☐ Ileostomy	☐ O_2	☐ Trach	Wounds	☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/ Frequency:		☐ Venous	Stage(s):
☐ Dialysis/Days	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Personal Safety	Does Member have stairs at home?	☐ Yes	☐ No	How Many:	
	Does Member experience frequent falls?	☐ Yes	☐ No		
	Does Member have vision or hearing loss?	☐ Yes	☐ No	☐ Glasses	☐ Hearing Aids
	Indicate all appropriate assistive device(s) Member uses:	☐ Wheelchair	☐ Cane	☐ Walker	☐ Other
	• Ambulation x ft.	☐ Independent	☐ Max Assist	☐ Mod	☐ Min
	• Safety/Balance		☐ Good	☐ Fair	☐ Poor

Current Level of Functioning:

Discharge Plan:

ADMISSION PACKET CHECKLIST (PLEASE SEND WITH ALL NEW)

Facesheet	☐ Yes	☐ No	**H & P**	☐ Yes	☐ No
Physician Orders	☐ Yes	☐ No	**Wound Notes** (If applicable)	☐ Yes	☐ No
IFT (Inter-facility transfer form)	☐ Yes	☐ No	**SNF Initial**	☐ Yes	☐ No
MC171	☐ Yes	☐ No	**Therapy Evaluation** (Skilled)	☐ Yes	☐ No
MDS (Custodial)	☐ Yes	☐ No	**Assigned SNFIST**	☐ Yes	☐ No

MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY.

Name the Drug(s):	Strength:	Frequency Taken:

Date of Review _____ Nurse Reviewer Printed Name _____ Nurse Reviewer Signature _____ Contact Phone Number _____