LTC FOLLOW-UP 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.

Facility:						
Name *(Last, First, M.I.):*			**DOB:**	**Reference #**	**ID #**	
Activity Level:				**Height:**	**Weight:**	
DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo					#hrs/month:	
Cognitive Status Alert/Oriented:	☐ x1	☐ x2	☐ x3	☐ x4		
Criteria Met for Continued Stay:	☐ Yes	☐ No	If yes, please describe deficit:			
Behavioral Change:	☐ Yes	☐ No	If yes, please describe:			
Dietary Change:	☐ Yes	☐ No	If yes, please describe:			
Medical Change:	☐ Yes	☐ No	If yes, please describe:			
Medication Change:	☐ Yes	☐ No	If yes, please describe:			
Skin Condition Change:	☐ Yes	☐ No	If yes, please describe:			
Any Falls Since Last Review:	☐ Yes	☐ No	If yes, please describe:			
Does SNF Facility Provide Transportation?:	☐ Yes	☐ No	If no, please indicate needs:	☐ O_2	☐ Cane	☐ Gurney ☐ Wheelchair

CONTINUED CARE NEEDS

Resident Care Needs *(Check all conditions that apply):*

☐ 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	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Activity Level	Bed Mobility	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Supine to Sit	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Sit to Supine	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent

Indicate all appropriate assistive device(s) Member uses:			☐ Wheelchair	☐ Cane	☐ Walker	☐ Other
• Gait Distance	x	ft.				
• Wheelchair Mobility	x	ft.	☐ Min	☐ Mod	☐ Max Assist	☐ Independent
• Safety/Balance	☐ Good	☐ Fair	☐ Poor			
• Endurance	☐ Good	☐ Fair	☐ Poor			
• Dressing Upper Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Dressing Lower Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Toileting	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Bathing	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Personal Hygiene	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		

Treatment Goals Set:

Treatment Goals Met:

Comments/Other (e.g. Specialty Consultation):

Updates to Discharge Plan:

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