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| iehphartSNF 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:** 🞎 O2 🞎 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 | 🞎 O2 | 🞎 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:** |
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Date of Review Nurse Reviewer Printed Name Nurse Reviewer Signature Contact Phone Number