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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:** | | | | | | | | | |
|  | | | | | |  | | | | | | | | | |  | | | | | | | | | |
|  | | | | | |  | | | | | | | | | |  | | | | | | | | | |

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