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

Facility name:	
Facility contact name and title/email:	
Facility fax/phone number:	
Member name:	**Date of birth (DOB):**
Admit date/authorization number/service reference number (SRN):	
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:**

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_____**	**Update_____**
Feeding					
Grooming					
Bathing					
Dressing – upper body					
Dressing – lower body					
Toileting/hygiene					
Transfer – toilet					
Transfer – tub/shower					

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PHYSICAL THERAPY (Daily notes not needed)	Update_____	Update_____	Update_____	Update_____	Update_____
Bed mobility					
Transfer – chair/WC					
Member name:				DOB:	
Gait – distances/assist					
Assistive device? Y/N and type					
Number of stairs currently and assistance needed?					
Wheelchair mobility					
Home evaluation needed? Y/N and date scheduled					
SPEECH THERAPY (Please attach notes)					
Diet – liquid, mech. 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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