CLINICAL AND THERAPY REQUEST FORM

Updates 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 PCP appointment date and time.*

Facility Name:							
Facility Contact Name & Title/Email:							
Facility Fax/Phone Number:							
Member Name:				**DOB:**			
Admit Date/Authorization Number/Service Reference Number (SRN):							
Community PCP - Name & Phone Number:							
Pharmacy Name and Phone:							
Advance Directives? Y/N & 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							
PHYSICAL THERAPY ***Daily notes not needed****	***Update*_____**	***Update*_____**	***Update*_____**	***Update*_____**	***Update*_____**		
Bed Mobility							
Transfer - Chair/WC							

Member Name:			DOB:		
PHYSICAL THERAPY cont'd. ***Daily notes not needed****	***Update_____***	***Update_____***	***Update_____***	***Update_____***	***Update_____***
Gait - Distance/Assist					
Assistive Device? Y/N & type					
Number of stairs currently & assist needed?					
Wheelchair Mobility					
Home Evaluation Needed? Y/N & 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 & 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 & 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 & contact number		