SNF/REHAB FACILITY FORM – Priority Health Medicare ONLY
Fax form to: 616 975-8848

PLEASE complete form as much as possible with each review. Please fax each patient review separately.

ACCEPTING TRANSFER FROM - ADMIT DATE: ______________

☐ **Hospital – Facility Name** ______________________________ ☐ Other – Describe ______________________________

ADMIT INFORMATION:

Facility Name:__________________________ City: _________________ Level of Care: ☐ **Acute** ☐ **Subacute** ☐ **LTAC**

Contact:______________________________ Phone: _________________________ Fax: __________________________

Diagnosis: ____ Facility/Attending Physician: ______________________

Member Information:

Name: ________________________________ ID#: __________________________________ DOB: __________________

Other Family Contact: ____ Phone: _________________

PCP: ________________________________ Advanced Directive: ☐ Yes ☐ No Advance Care Planning: ________________

Prior Level of Function:____

WEEKLY REVIEW UPDATE - DATE: ______________ **(Reviews are due every 7 days)**

Therapy Information:

Therapy Goals:____

DME use:____ Ambulation (distance): __________________________

Comments:____

Assistance w/transfers/mobility: ☐ total ☐ max ☐ mod ☐ min ☐ Sup ☐ MI ☐ Ind

Assistance w/bathing/grooming: ☐ total ☐ max ☐ mod ☐ min ☐ Sup ☐ MI ☐ Ind

Cognitive Status: _____________ Hours/day in PT: _____OT:_____ SLP: _____ Days/week in PT: _____OT: _____SLP: _____

Patient's level of participation in therapies:____

Next Patient Care Conference:____

Home Evaluation Completed? ☐ YES ☐ NO Scheduled Date:________________

Nursing Care Provided: (wound care; pain management; co-morbid status; medical history; etc.)

DISCHARGE PLANNING UPDATE: ***(To be initiated with first review)***

Anticipated D/C Site and Date (home or name/type of facility): ____

Caregiver Support Status/Assistance at home/needs: ____

DISCHARGE SUMMARY – ACTUAL DISCHARGE DATE: _____________

PLEASE fax Discharge Summary and medication list to Priority Health within 24 hours of discharge.

Discharged to: ____

Care Needs/Assistance Needed:____

Cognitive Status at time of discharge: ____

Follow-up Appointments: ____

Service Referrals Made (HHC; DME; Comm. Resources):____

____

COMMENTS: ____

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