

SNF/REHAB Facility Review Form

Fax form to: 616-975-8848



Member

Date: _____

Last Name: _____

First Name: _____

ID #: _____

DOB: _____

Facility Contact: _____

Facility Phone: _____

Diagnosis/ICD9 Code: _____

Advanced Directive: Yes No

Therapy

OT/POC

- Bathing: total max mod min MI ind
- Dress UB: total max mod min MI ind
- Dress LB: total max mod min MI ind
- Groom: total max mod min MI ind
- Toilet: total max mod min MI ind

Other/Notes: _____

Goals:

ST _____

LT _____

PT/POC

- Transfer: total max mod min MI ind
- Bed Mobility: total max mod min MI ind
- Ambulate: total max mod min MI ind
- W/C Mobility: total max mod min MI ind

Device: _____ Distance: _____

Stairs: _____

Other/Notes: _____

Goals:

ST _____

LT _____

ST/POC

Swallow deficits: _____

Diet: _____

Goals:

ST _____

LT _____

Other/Notes: _____

Nursing/POC

Skin/Wound Care and Location: _____

Size: _____ L, by: _____ W, by: _____ D

Treatment: _____

Pain/Location: _____

Medication/Dosage/Frequency: _____

Other/Notes: _____

Discharge

Date: _____ Place/Disposition: _____

Member Phone: _____ Contact Name/Phone (if other than patient's home): _____

Home Care Agency: _____ Phone Number: _____

DME Provider: _____ Phone Number: _____

Follow up appt(s)/Names/Contact Information: _____

Other: _____

Please fax updates to 616 975-8848. Please view authorizations and days added at priorityhealth.com. Due to increased volume, our nurse case managers may not be able to call you with added days. We **will** contact you, however, if we need more information or have questions.

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