

(A) FACILITY INFORMATION Facility To: _____ (B) DEMOGRAPHIC INFORMATION Individual's DOB: ____/____/____ Sex: ____ Race: ____ Individual's Last Name: _____ First Name: _____ Initial: _____ Individual's Address: _____ Phone Number: _____ Nearest Relative/Health Care Surrogate: _____ Phone Number: _____ PHYSICIAN INFORMATION Name: _____ Will you care for individual in NF? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, referred to: _____ Principal Diagnosis: _____ Secondary Diagnosis: _____ Discharge Diagnosis: _____ (Problem List may be attached) Surgery Performed & Date: ____/____/____ Allergy/Drug Sensitivity: _____ MEDICATION AND TREATMENT ORDERS (copies may be attached) _____ _____ _____ _____ (C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION (Complete for admission to NF only) 1. Is dementia the primary diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is there an indication of, or diagnosis of serious mental illness (SMI), such as: (check all that apply) <table style="width: 100%;"><tr><td><input type="checkbox"/> Schizophrenia</td><td><input type="checkbox"/> Panic or severe anxiety disorder</td></tr><tr><td><input type="checkbox"/> Mood disorder</td><td><input type="checkbox"/> Personality disorder</td></tr><tr><td><input type="checkbox"/> Somatoform disorder</td><td><input type="checkbox"/> Other psychotic or mental disorder</td></tr><tr><td><input type="checkbox"/> Paranoia</td><td><input type="checkbox"/> Leading to chronic disability</td></tr></table> 4. Has the individual received MR services within the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is the individual a danger to self or others? (please attach explanation) <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the individual on any medication for the treatment of a serious mental illness or psychiatric diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. If yes, is the MR or psychiatric diagnosis controlled with medication? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Is the individual being admitted from a hospital after receiving acute inpatient care? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Does the individual require nursing facility services for the condition for which he/she received care in the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Has the physician certified the individual is likely to require less than 30 days of nursing facility services? <input type="checkbox"/> Yes <input type="checkbox"/> No (D) ADDITIONAL ORDERS (Orders may be attached) _____ _____ _____ _____ (E) HISTORY & PHYSICAL AND LABS 1. PHYSICAL EXAM (History & Physical may be attached) Head/Ears/Eyes/Nose & Throat (HENT): _____ _____ Neck: _____ Cardiopulmonary: _____ _____ Abdomen: _____ GU: _____ Rectal: _____ Extremities: _____ Neurological: _____ Other: _____ Free from communicable diseases <input type="checkbox"/> Yes <input type="checkbox"/> No 2. LABORATORY FINDINGS (Reports may be attached) TB Test <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____ Results: _____ Chest X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____ Results: _____ (F) IMMUNIZATIONS GIVEN <table style="width: 100%;"><tr><td><input type="checkbox"/> Pneumococcal Vaccine</td><td>Date: ____/____/____</td></tr><tr><td><input type="checkbox"/> Influenza Vaccine</td><td>Date: ____/____/____</td></tr><tr><td><input type="checkbox"/> Tetanus and Diphtheria Vaccine</td><td>Date: ____/____/____</td></tr><tr><td><input type="checkbox"/> Herpes Zoster Vaccine</td><td>Date: ____/____/____</td></tr></table> (G) PHYSICAL THERAPY (Attach Orders) <input type="checkbox"/> New Referral <input type="checkbox"/> Continuation of Therapy FREQUENCY OF THERAPY INSTRUCTIONS <table style="width: 100%;"><tr><td><input type="checkbox"/> Stretching</td><td><input type="checkbox"/> Coordinating Activities</td><td><input type="checkbox"/> Progress bed to wheelchair</td></tr><tr><td><input type="checkbox"/> Passive Range of Motion (ROM)</td><td><input type="checkbox"/> Non-weight bearing</td><td><input type="checkbox"/> Recovery to full function</td></tr><tr><td><input type="checkbox"/> Active assistive</td><td><input type="checkbox"/> Partial weight bearing</td><td><input type="checkbox"/> Wheelchair independent</td></tr><tr><td><input type="checkbox"/> Active</td><td><input type="checkbox"/> Full weight bearing</td><td><input type="checkbox"/> Complete ambulation</td></tr></table> PRECAUTIONS: Sensation Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No Resist Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cardiac <input type="checkbox"/> Other ADDITIONAL THERAPIES (Attach Orders) <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Other (H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders) <table style="width: 100%;"><tr><td><input type="checkbox"/> Catheter Care</td><td><input type="checkbox"/> Diabetic Care</td></tr><tr><td><input type="checkbox"/> Changing Feeding Tube</td><td><input type="checkbox"/> Monitor Blood Sugar/Frequency</td></tr><tr><td><input type="checkbox"/> Dressing Changes</td><td><input type="checkbox"/> Administer Insulin</td></tr><tr><td><input type="checkbox"/> Ostomy Care</td><td><input type="checkbox"/> Tube Feeding</td></tr><tr><td><input type="checkbox"/> Wound Care</td><td><input type="checkbox"/> Oxygen (Select from below)</td></tr><tr><td><input type="checkbox"/> Suctioning</td><td><input type="checkbox"/> PRN</td></tr><tr><td><input type="checkbox"/> Trach Care</td><td><input type="checkbox"/> Continuous @L/min</td></tr></table> Instructions: _____ (I) SPECIAL DIET ORDERS (Orders may be attached) _____ _____ (J) TYPE OF CARE RECOMMENDED (MUST BE COMPLETED AND SIGNED) Check one <input type="checkbox"/> Skilled Nursing Extended Care Facility (ECF), Duration: _____ <input type="checkbox"/> Intermediate Care: Duration: _____ I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization. <input type="checkbox"/> I certify that this individual is in need of Medicaid Waiver Services in lieu of institutional placement. Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Admission Date to Nursing Facility: ____/____/____ Effective Date of Medical Condition: ____/____/____ Print Physician's Name: _____ Address: _____ Phone Number: _____ Fax: _____ Email Contact Address: _____ _____ _____ Physician's Signature and Date Required: _____ _____ _____ _____ <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 10px;">FOR ONLINE APPLICANT USE ONLY IF APPLYING FOR MEDICAID, PLEASE INCLUDE DCF ACCESS CONFIRMATION NUMBER BELOW:</div>	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Panic or severe anxiety disorder	<input type="checkbox"/> Mood disorder	<input type="checkbox"/> Personality disorder	<input type="checkbox"/> Somatoform disorder	<input type="checkbox"/> Other psychotic or mental disorder	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Leading to chronic disability	<input type="checkbox"/> Pneumococcal Vaccine	Date: ____/____/____	<input type="checkbox"/> Influenza Vaccine	Date: ____/____/____	<input type="checkbox"/> Tetanus and Diphtheria Vaccine	Date: ____/____/____	<input type="checkbox"/> Herpes Zoster Vaccine	Date: ____/____/____	<input type="checkbox"/> Stretching	<input type="checkbox"/> Coordinating Activities	<input type="checkbox"/> Progress bed to wheelchair	<input type="checkbox"/> Passive Range of Motion (ROM)	<input type="checkbox"/> Non-weight bearing	<input type="checkbox"/> Recovery to full function	<input type="checkbox"/> Active assistive	<input type="checkbox"/> Partial weight bearing	<input type="checkbox"/> Wheelchair independent	<input type="checkbox"/> Active	<input type="checkbox"/> Full weight bearing	<input type="checkbox"/> Complete ambulation	<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Diabetic Care	<input type="checkbox"/> Changing Feeding Tube	<input type="checkbox"/> Monitor Blood Sugar/Frequency	<input type="checkbox"/> Dressing Changes	<input type="checkbox"/> Administer Insulin	<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Oxygen (Select from below)	<input type="checkbox"/> Suctioning	<input type="checkbox"/> PRN	<input type="checkbox"/> Trach Care	<input type="checkbox"/> Continuous @L/min
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