

<p>(A) FACILITY INFORMATION</p> <p>Facility To _____</p>	<p>Facility From _____</p> <p>Admission Date _____ Discharge Date _____</p>	<p>(E) HISTORY & PHYSICAL AND LABS</p> <p>1. PHYSICAL EXAM (History & Physical may be attached)</p> <p>Head/Ears/Eyes/Nose & Throat (HENT) _____</p> <p>Neck _____</p> <p>Cardiopulmonary _____</p> <p>Abdomen _____</p> <p>GU _____</p> <p>Racial _____</p> <p>Extremities _____</p> <p>Neurological _____</p> <p>Other _____</p> <p>Free from communicable diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. LABORATORY FINDINGS (Reports may be attached)</p> <p>TB Test <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____/_____/_____</p> <p>Results _____</p> <p>Chest X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____/_____/_____</p> <p>Results _____</p>																						
<p>(B) DEMOGRAPHIC INFORMATION</p> <p>Individual's DOB _____/_____/_____ Sex _____ Race _____</p> <p>Individual's Last Name _____ First Name _____ Initial _____</p> <p>Individual's Address _____ Phone Number _____</p> <p>Nearest Relative/Health Care Surrogate _____ Phone Number _____</p>	<p>(F) IMMUNIZATIONS GIVEN</p> <p><input type="checkbox"/> Pneumococcal Vaccine Date _____/_____/_____</p> <p><input type="checkbox"/> Influenza Vaccine Date _____/_____/_____</p> <p><input type="checkbox"/> Tetanus and Diphtheria Vaccine Date _____/_____/_____</p> <p><input type="checkbox"/> Herpes Zoster Vaccine Date _____/_____/_____</p>																							
<p>PHYSICIAN INFORMATION</p> <p>Name _____</p> <p>Will you care for individual in NF? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, referred to _____</p> <p>Principal Diagnosis _____</p> <p>Secondary Diagnosis _____</p> <p>Discharge Diagnosis _____</p> <p>(Problem List may be attached)</p> <p>Surgery Performed & Date _____/_____/_____</p> <p>Allergy/Drug Sensitivity _____</p>	<p>(G) PHYSICAL THERAPY (Attach Orders)</p> <p><input type="checkbox"/> New Referral <input type="checkbox"/> Continuation of Therapy</p> <p>FREQUENCY OF THERAPY INSTRUCTIONS</p> <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> <p>PRECAUTIONS:</p> <p><input type="checkbox"/> Progressive resistive</p>		<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"/> Sensation impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No								
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<input type="checkbox"/> Active	<input type="checkbox"/> Full weight bearing	<input type="checkbox"/> Complete ambulation																						
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Restrict Activity:	<input type="checkbox"/> Yes <input type="checkbox"/> No																						
<input type="checkbox"/> Other _____																								
<p>(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION (Complete for admission to NF only)</p> <p>1. Is dementia the primary diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>3. Is there an indication of, or diagnosis of serious mental illness (SMI), such as: (Check all that apply)</p> <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 leading to chronic disability</td> </tr> <tr> <td><input type="checkbox"/> Paranoia</td> <td></td> </tr> </table> <p>4. Has the individual received MR services within the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Is the individual a danger to self or others? (please attach explanation) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>7. If yes, is the MR or psychiatric diagnosis controlled with medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Is the individual being admitted from a hospital after receiving acute inpatient care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>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</p>	<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 leading to chronic disability	<input type="checkbox"/> Paranoia		<p>(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)</p> <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> <p>Instructions _____</p>		<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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<p>(D) ADDITIONAL ORDERS (Orders may be attached)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>(I) SPECIAL DIET ORDERS (Orders may be attached)</p> <p>_____</p> <p>_____</p>																							
<p>(J) TYPE OF CARE RECOMMENDED (MUST BE COMPLETED AND SIGNED)</p> <p>Check one</p> <p><input type="checkbox"/> Skilled Nursing Extended Care Facility (ECF), Duration _____</p> <p><input type="checkbox"/> Intermediate Care: Duration _____</p> <p>I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.</p> <p><input type="checkbox"/> I certify that this individual is in need of Medicaid Waiver Services in lieu of institutional placement.</p> <p>Print Physician's Name _____</p> <p>Address _____</p> <p>Phone Number _____ Fax _____</p> <p>Email Contact Address _____</p> <p>Physician's Signature and Date Required _____/_____/_____</p>																								
<p>Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Admission Date to Nursing Facility _____/_____/_____</p> <p>Effective Date of Medical Condition _____/_____/_____</p>																								

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