MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

A. PATIENT INFORMATION

Gender: ☐ Male ☐ Female
Hispanic Ethnicity: ☐ Yes ☐ No
Race: ☐ White ☐ Black ☐ Other: _____
Language: ☐ English ☐ Other:

B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Normal ☐ Impaired
☐ Blind ☐ Deaf ☐ Hearing Aid L R

C. DECISION MAKING CAPACITY (PATIENT):

☐ Capable to make healthcare decisions ☐ Requires a surrogate

D. EMERGENCY CONTACT

Name: _____ Name: _____
Phone: Phone:

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge:
Reason for transfer (Brief Summary):

Surgical procedures performed during stay: ☐ None

Other diagnoses:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MIDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____

Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

G. PATIENT RISK ALERTS

☐ None Known ☐ Harm to self ☐ Difficulty swallowing
☐ Elopement ☐ Harm to others ☐ Seizures
☐ Pressure Ulcers ☐ Falls ☐ Other: _____

RESTRAINTS: ☐ Yes ☐ No
Types:

Reasons for use:

ALLERGIES: ☐ None Known ☐ Yes, List below:

Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DO NOT Resuscitate (DNR)	☐ Yes	☐ No
DO NOT Intubate	☐ Yes	☐ No
DO NOT Hospitalize	☐ Yes	☐ No
No Artificial Feeding	☐ Yes	☐ No
Hospice	☐ Yes	☐ No

I. TRANSFERRED FROM

Facility Name:	
Date:	Unit:
Phone:	Fax:
Discharge Nurse:	Phone:
Admit Date: Admit Time:	Discharge Date: Discharge Time:

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:
☐ Antibiotics	Date:	Time:
☐ Insulin	Date:	Time:
☐ Other:	Date:	Time:

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time:

N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ **Medication Reconciliation** ☐ Lab reports
☐ Discharge Medication List ☐ X-ray ☐ EKG
☐ PASRR Forms ☐ CT Scan ☐ MRI
☐ Social and Behavioral History

ALL MEDICATIONS: (MAY ATTACH LIST)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

O. VITAL SIGNS

Date:	Time Taken:	
HT:	WT:	
Temp:	BP:	
HR:	RR:	Sp02:

P. PATIENT HEALTH STATUS

Bladder: ☐ Continent ☐ Incontinent
☐ Ostomy ☐ Catheter Type: _____ date inserted: _____
Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____
Indications for use:
☐ Urinary retention due to: _____
☐ Monitoring intake and output
☐ Skin Condition: _____
☐ Other: _____
Attempt to remove catheter made in hospital? ☐ Yes ☐ No
Date Removed: _____
Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy
Date of Last BM: _____
Immunization status:
Influenza: ☐ Yes ☐ No Date: _____
Pneumococcal: ☐ Yes ☐ No Date:

Q. NUTRITION / HYDRATION

Dietary Instructions:

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG
Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

S. PHYSICAL FUNCTION

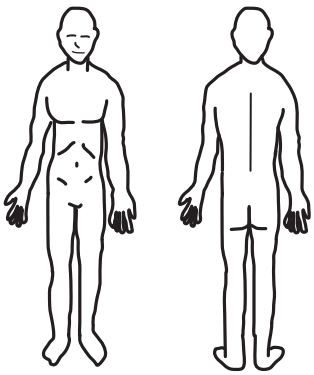
Ambulation:
☐ Not ambulatory
☐ Ambulates independently
☐ Ambulates with assistance
☐ Ambulates with assistive device

Transfer:
☐ Self
☐ Assistance
☐ 1 Assistant
☐ 2 Assistants

Devices:
☐ Wheelchair (type):
☐ Appliances:
☐ Prosthesis:
☐ Lifting Device:

Weight-bearing:
Left:
☐ Full ☐ Partial ☐ None
Right:
☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers
(Indicate stage and location(s) of lesions using corresponding number:
1.
2
3.

List any other lesions or wounds:

U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, and cannot follow simple instructions
☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:
☐ IV / PICC / Portacath Access - Date inserted:
Type: _____
☐ Internal Cardiac Defibrillator ☐ Pacemaker
☐ Wound Vac
☐ Other: _____
Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP
☐ Nebulizer ☐ Other: _____ ☐ Nasal Cannula
☐ Mask: Type _____
☐ Oxygen - liters: ____% ☐ PRN ☐ Continuous
☐ Trach Size: _____ Type: _____
Ventilator Settings: _____
☐ Suction

W. PERSONAL ITEMS

☐ Artificial Eye ☐ Prosthetic ☐ Walker
☐ Contacts ☐ Cane ☐ Other
☐ Eyeglasses ☐ Crutches
☐ Dentures ☐ Hearing Aids
☐ U ☐ L ☐ Partial ☐ L ☐ R

X. COMMENTS (Optional)

Signature: _____

Printed Name: _____

Y. PHYSICIAN CERTIFICATION

☐ I certify the individual requires nursing facility (NF) services.
☐ The individual received care for this condition during hospitalization.
☐ I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Rehab Potential (check one)
☐ Good ☐ Fair ☐ Poor

Effective date of medical condition _____

Physician/ARNP Signature: _____ Date: _____

Printed Physician/ARNP Name & Title: _____ Phone Number: _____

Person completing form: _____ Phone Number: _____ Date: _____