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: ____

This facsimile transmission contains confidential information. The information is intended solely for use by the individual entity named as the recipient hereof. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this transmission is prohibited. If you have received this transmission in error, please notify us by telephone immediately so we may arrange to retrieve this transmission at no cost to you.