Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Rehabilitation Assessment Form

Complete this form and fax it to: 1-866-534-9994

Include hospital admission H&P and any PM&R consultation notes. For BCN Advantage HMO-POS℠ members in a SNF, fax signed / dated *NOMNC* form prior to discharge.

Today's date:

ASSESSMENT TYPE / COVERAGE

Assessment type: ☐ Initial assessment ☐ Reassessment | **Plan:** ☐ BCN HMO℠ ☐ BCN Advantage℠ ☐ BlueCaid

MEMBER / FACILITY INFORMATION

Member name: | **Age:**

Contract number:

Admitting facility:

Admission type: ☐ SNF ☐ IP rehab ☐ LTACH

Authorization number:

Facility reviewer for updates:

Phone: | **Fax:**

Team conference day:

ADMISSION INFORMATION

(Complete this section for the initial assessment only.)

Admission date (facility):

Facility doctor first / last name:

DX:

PMH:

PSH:

Height: | **Weight:**

Prior level of function (home):

Home configuration:

No. of steps at entry:

Location of: Bed: Bath:

CLINICAL INFORMATION / BASICS

Vital signs: T P R BP

Cognition / A&O: ☐ x1 ☐ x2 ☐ x3

Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy

Bladder: ☐ Continent ☐ Incontinent ☐ Cath / Type:

Diet: ☐ NPO or ☐ Type:

Tube feeding: Formula / Rate:

O2 delivery: Type: Sats:

Respiratory tx: ☐ Yes ☐ No

Trach: Type: Size:

Suction frequency/24H:

Pain location / mgt:

MOBILITY CURRENT FUNCTIONING (Use key below.*)

Bed mobility:

Transfers:

Gait / Distance: **Assist level:**

Assistive device: ☐ None or ☐ Type:

Stairs / Ascending, descending: ☐ Not applicable or

No. of stairs: Handrails: Assist needed:

WC mobility:

Distance: Assist needed:

SELF-CARE CURRENT FUNCTIONING (Use key below.*)

Feeding:

Grooming:

Bathing / UE: **LE:**

Dressing / UE: **LE:**

Toileting / Hygiene Mgt:

ADL transfers:

Comments:

SPEECH THERAPY CURRENT STATUS

☐ **None or** ☐ **Dysphagia Eval. / Modified Barium Swallow Results / Aspiration Risk / Recommendations:**

CLINICAL INFORMATION / MEDICATIONS

IV medications, with ending dates:

Vascular access:

Significant medications that affect functioning:

CLINICAL INFORMATION / SKIN STATUS

Skin status: ☐ Intact or...

If not intact, complete fields below and add pages as needed.

Wound or incision / Location 1 -- Stage:

Size: L x W x D (cm):

Treatment:

Wound or incision / Location 2 -- Stage:

Size: L x W x D (cm):

Treatment:

DISCHARGE (DC) PLANS

DC date (tentative):

DC with: ☐ HHC provider:

☐ OP provider:

DC equipment (prior auth required):**

DC destination:

Member to live with:

Supervision needs:

DC goals:

***Key for mobility and self-care functioning:**

I = independent / MI = modified independent / Sup = supervision
SBA = standby assist / CGA = contact guard assist / Min = minimal
Mod = moderate / Max = maximum / Total = total assist

****For BlueCaid members, call BlueCaid Provider Inquiry at 1-800-688-3290. For other members, contact Northwood at 1-800-667-8496 (for DME) or J&B Medical Supply at 1-888-896-6233 (for diabetic supplies).**

Revised December 2011

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Contract number:	**Today's date:**

ADDITIONAL NOTES