Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Rehabilitation Assessment Form

Today's date:

Complete this form and fax it to: 1-844-869-4073
Include hospital admission H&P and any PM&R consultation notes. For HMO-PPO members in a SNF, fax signed / dated *NOMNC* form prior to discharge.

ASSESSMENT TYPE / COVERAGE

Assessment type: ❑ Initial assessment ❑ Reassessment | **Plan:** ❑ HMO ❑ PPO

MEMBER / FACILITY INFORMATION

Member name: **Age:**	**Authorization number:**
Contract number:	**Facility reviewer for updates:**
Admitting facility:	**Phone:** **Fax:**
Admission type: ❑ SNF ❑ IP rehab	**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:

CLINICAL INFORMATION / MEDICATIONS

IV medications, with ending dates:
Vascular access:
Significant medications that affect functioning:

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

Feeding:
Grooming:
Bathing / UE: **LE:**
Dressing / UE: **LE:**
Toileting / Hygiene Mgt:
ADL transfers:
Comments:

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:

SPEECH THERAPY CURRENT STATUS

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

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

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1-8[illegible] -[illegible]
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Member name:	**Admitting facility:**
Contract number:	**Today's date:**

ADDITIONAL NOTES

Revised August 2015