

Rehabilitation Assessment Form

**Complete this form and fax it to:
1-844-869-4073**

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

Today's date:

ASSESSMENT TYPE / COVERAGE	
Assessment type: <input type="checkbox"/> Initial assessment <input type="checkbox"/> Reassessment	Plan: <input type="checkbox"/> Medi-Pak® Advantage HMO <input type="checkbox"/> Medi-Pak® Advantage PPO
MEMBER / FACILITY INFORMATION	
Member name:	Age:
Contract number:	Authorization number:
Admitting facility:	Facility reviewer for updates:
Admission type: <input type="checkbox"/> SNF <input type="checkbox"/> IP rehab	Phone: <input type="text"/> Fax: <input type="text"/>
	Team conference day:
ADMISSION INFORMATION (Complete this section for the initial assessment only.)	CLINICAL INFORMATION / BASICS
Admission date (facility):	Vital signs: T P R BP
Facility doctor first / last name:	Cognition / A&O: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3
DX:	Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Ostomy
PMH:	Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Cath / Type:
PSH:	Diet: <input type="checkbox"/> NPO or <input type="checkbox"/> Type:
Height: <input type="text"/> Weight: <input type="text"/>	Tube feeding: Formula / Rate:
Prior level of function (home):	O2 delivery: Type: <input type="text"/> Sats: <input type="text"/>
Home configuration: No. of steps at entry:	Respiratory tx: <input type="checkbox"/> Yes <input type="checkbox"/> No
Location of: Bed: <input type="text"/> Bath: <input type="text"/>	Trach: Type: <input type="text"/> Size: <input type="text"/>
	Suction frequency/24H: <input type="text"/>
	Pain location / mgt: <input type="text"/>
MOBILITY CURRENT FUNCTIONING (Use key below.*)	CLINICAL INFORMATION / MEDICATIONS
Bed mobility:	IV medications, with ending dates:
Transfers:	Vascular access:
Gait / Distance: <input type="text"/> Assist level: <input type="text"/>	Significant medications that affect functioning:
Assistive device: <input type="checkbox"/> None or <input type="checkbox"/> Type: <input type="text"/>	
Stairs / Ascending, descending: <input type="checkbox"/> Not applicable or No. of stairs: <input type="text"/> Handrails: <input type="text"/> Assist needed: <input type="text"/>	CLINICAL INFORMATION / SKIN STATUS
WC mobility: Distance: <input type="text"/> Assist needed: <input type="text"/>	Skin status: <input type="checkbox"/> Intact or...
	If not intact, complete fields below and add pages as needed.
SELF-CARE CURRENT FUNCTIONING (Use key below.*)	Wound or incision / Location 1 -- Stage: <input type="text"/>
Feeding:	Size: L x W x D (cm): <input type="text"/>
Grooming:	Treatment: <input type="text"/>
Bathing / UE: <input type="text"/> LE: <input type="text"/>	Wound or incision / Location 2 -- Stage: <input type="text"/>
Dressing / UE: <input type="text"/> LE: <input type="text"/>	Size: L x W x D (cm): <input type="text"/>
Toileting / Hygiene Mgt:	Treatment: <input type="text"/>
ADL transfers:	DISCHARGE (DC) PLANS
Comments:	DC date (tentative): <input type="text"/>
SPEECH THERAPY CURRENT STATUS	DC with: <input type="checkbox"/> HHC provider: <input type="checkbox"/> OP provider:
<input type="checkbox"/> None or <input type="checkbox"/> Dysphagia Eval. / Modified Barium Swallow Results / Aspiration Risk / Recommendations:	DC equipment (prior auth required**): <input type="text"/>
	DC destination: <input type="text"/>
	Member to live with: <input type="text"/>
	Supervision needs: <input type="text"/>
	DC goals: <input type="text"/>

*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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SNF, fax signed / dated NOMNC form prior to discharge.

Member name:	Admitting facility:
Contract number:	Today's date:

ADDITIONAL NOTES