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Skilled nursing facility/rehabilitation precertification worksheet
Fax this form with cover sheet to 1-866-920-6005.

Date:

Facility information	
Acute care facility:	
Acute care facility contact & phone number:	
Skilled nursing facility (SNF) admit date:	
SNF/rehab facility name:	**Facility NPI:**
Facility address, city, state and ZIP code:	
SNF/rehab contact & phone number: **Email:**	
Medical doctor (M.D.) who will follow member at SNF/rehab (first and last name):	
M.D. address, city, state and ZIP:	
Member name:	**Member ID # and/or date of birth:**

Past medical history (PMH) & rationale for admission		
Admitting diagnosis:		
Reason for SNF/rehabilitation admission:		
Alternative resources evaluated? **Home health_____ In-home physical therapy, occupational therapy, speech therapy_____** **Outpatient therapy (OP) _____ Home infusion_____**		
Home set up:	**1 floor ___ 2 floors ____ Multi-level _____** **Steps to home_____ Rails: Yes__ or No__**	**Bed 1st floor Yes__ or No__** **Bath 1st floor: Yes__ or No__**
Social history:		
Lives with:_____ **Available 24 hours: Yes__ or No___**		
Family contact/power of attorney (POA):_____	**Phone:**	
Living will Yes__ or No__	**Health care proxy Yes__ or No__**	
Prior level of function:		
Cognition:		
Medical history:		
Medical/nursing considerations: (any abnormalities, i.e., respiratory, pain management, ostomy care, peg tube, cognitive/communication issues) **IV Medicines:**		
Nutrition:		

Wounds: (type of wound, wound measurements, staging, summary of wound care)
Therapies
Date initial therapy evaluation completed:
Current therapy status as of date:
Expected therapy discharge date:
Ambulation & mobility (examples: distance, weight bearing status, device used)
Evaluation: **Goal:** **Current status:**
Transfers
Evaluation: **Goal:** **Current status:**
Stairs
Evaluation: **Goal:** **Current status:**
Balance
Evaluation: **Goal:** **Current status:**
Occupational therapy/activities of daily life
Bathing
Evaluation: **Goal:** **Current status:**
Dressing
Evaluation: **Goal:** **Current status:**
Toilet transfers
Evaluation: **Goal:** **Current status:**
Speech therapy
Evaluation: **Goal:** **Current status:**
Discharge plan
Plan on admission:
Anticipated discharge date:
Updated plan with concurrent reviews:
Barriers to discharge:
Patient/family teaching needs:

Home health agency referral: Yes____ No____	**Home evaluation done: Yes___No___N/A____**

Agency:	
Durable medical equipment/other equipment:	
Community referrals: **Case management_____** **Choices_____**	
Community resources already in place: (Meals on Wheels, senior housing)	
Follow -up M.D. appointment scheduled: (name, address and number)	
Follow-up appointment date:	
Transportation needs: Yes_____ No_____	
Discharge contact name/phone number (if different from POA):	
Discharge disposition/location (home, relative):	
If additional days are being requested	
Requested days:	
Reason for request:	
Last skilled date:	
Continued stay - planned discharge date:	
Cost effective alternatives explored: (home health, OP therapy, CHOICES, etc.)	