CONTINUED STAY AUTHORIZATION or DISCHARGE SUMMARY

Inpatient Rehab/SNF Team **Phone: (313) 664-8800** **Fax: (313) 664-5820**

Instructions: Complete form and fax to the number above. We follow InterQual criteria for review.

Member name: ____ **HAP ID#:** ____ **Today's date:** ____

Currently admitted to: ____ **Admission date:** ____

This progress report for dates of care (month/day/year) From: ____ **Through:** ____

Person completing form: ____ **Phone:** ____ **Fax:** ____

Care conference date: ____ **Family relationship assisting with plan of care:** ____

WEEKLY DISCHARGE PLANNING UPDATE

Anticipated discharge date: ____ **Actual discharge date:** ____

To: Own residence Assisted living **Reside with:** ____

Home care ordered: Yes No

Will transition to custodial care be needed? ____

Home evaluation date ____ **Findings** ____

Education completed by member/family: ____

Barriers to discharge: ____

CLINICAL STATUS

Cognitive status: Alert & orientated x 3 Alert & oriented x 2 Alert & orientated x 1 Not alert & oriented

Able Unable to follow 1 2 step directions (check one)

Behavioral symptoms:
(new onset or increasing) ____

NUTRITIONAL STATUS

Adequate **Not adequate** **Reason** ____ **Weight:** ____

Route: PO TPN GI tube Formula & rate ____

Date of last change to formula or rate: ____

Skin: Intact Not intact **(If not intact, complete wound assessment sheet)**

Pain scale:
(none) 0-10 (severe) ____ **Location:** ____

Pain medication (frequency & dose): ____

Pain managed? Yes No

IV THERAPY

Type of line and location: ____

IV medication(s) and dosage & frequency: ____

Expected duration of treatment ____ **Include end date of order** ____

Respiratory interventions/O2: ____ **O2 sat:** ____

Isolation for: ____ **Anti-infectants:** ____

Additional comments/issues/concerns: ____

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THIS SECTION TO BE COMPLETED FOR CONTINUED AUTHORIZATION OF THERAPY SERVICES.

THERAPY REHAB – FUNCTIONAL STATUS

*** Fields identified with an asterisk must be completed with submission of first review.**

KEY FOR PHYSICAL/OCCUPATIONAL THERAPY
7 = **Independence**
6 = **Modified Independence**
5 = **Stand By Assist**
4 = **Minimal Assist < 25%**
3 = **Moderate Assist 25–49%**
2 = **Maximum Assist 50–74%**
1 = **Dependent > 75%**
Balance: S= Static D= Dynamic -- Poor, Fair or Good

Member name: ______________________ **HAP ID#:** ______________________

OCCUPATIONAL THERAPY PROGRESS REPORT

	*Prior level of function	*Evaluation	*Week 1	Week 2	Week 3	Week 4	*Goal	Status on D/C
Enter Date		/ /	/ /	/ /	/ /	/ /		/ /
Eating								
Grooming								
Bathing UE								
Bathing LE								
Dressing UE								
Dressing LE								
Toileting								
Bed mobility								
Transfer-bed								
Transfer-toilet								
Sitting balance	S:	S:	S:	S:	S:	S:	S	S:
	D:	D:	D:	D:	D:	D:	D:	D:
Stand balance	S:	S:	S:	S:	S:	S:	S	S:
	D:	D:	D:	D:	D:	D:	D:	D:

ELOS for OT goal achievement: __________ **Client/family instructions:** ______________________

Comments:

Member name: ______________________ **HAP ID#:** ______________________

PHYSICAL THERAPY – PROGRESS REPORT

	*Prior level of function	*Evaluation	*Week 1	Week 2	Week 3	Week 4	*Goal	Status on D/C
Enter Date		/ /	/ /	/ /	/ /	/ /		/ /
Bed mobility								
Bed/mat transfers								
Gait								
Ambulation distance (feet)								
Wheelchair management								
Stairs								
Fall recovery								
Residential mobility								
Car transfers								
Community mobility								

ELOS for PT goal achievement: __________ **Client/family instructions:** ______________________

Comments:

Instructions: Complete form and fax to the number above. We follow InterQual criteria for review.

Member name: ______________________ HAP ID#: ______________________

SPEECH THERAPY PROGRESS REPORT

* Fields identified with an asterisk must be completed with submission of first review.

KEY FOR DYSPHAGIA TREATMENT
7 = **Independent** -Swallowing Within Functional Limits
6 = **Mod. Independent –** Swallowing almost always functional with added time
5 = **Supervision –** Swallowing almost always functional with added time and use of cues
4 = **Min –** Swallowing effective 75-90% of the time
3 = **Moderate –** Swallowing frequently effective 50-75%
2 = **Max –** Swallowing is severely impaired; functional 25-50%
1 = **Dependent –** Swallowing is totally dysfunctional. NPO

	*Prior level of function	*Evaluation	*Week 1	Week 2	Week 3	Week 4	*Goal	Status on D/C
Enter Date		/ /	/ /	/ /	/ /	/ /		/ /
Swallowing Liquids								
Pudding thick								
Honey thick								
Nectar thick								
Thin								
Swallowing solids								
Pureed								
Mechanical soft								
Regular								
Swallows medications								

* Fields identified with an asterisk must be completed with submission of first review.

KEY FOR APHASIA TREATMENT
6 = **Independent**
5 = **Adequate Function** (95%)
4 = **Mild Dysfunction** (75-95%)
3 = **Moderate Dysfunction** (50-75%)
2 = **Marked Dysfunction** (25-50%)
1 = **Severe Dysfunction** (0-25%)
DNT = **Did not Test**

	*Prior level of function	*Evaluation	*Week 1	Week 2	Week 3	Week 4	*Goal	Status on D/C
Enter Date		/ /	/ /	/ /	/ /	/ /		/ /
Receptive language								
Auditory								
Reading								
Expressive language								
Verbal								
Written expression								
Non-verbal expression								

ELOS for ST goal achievement: ____________ **Client/family instructions:** ______________________

Comments:

Instructions: Complete form and fax to the number above. We follow InterQual criteria for review.