SNF INITIAL REVIEW

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

Name *(Last, First, M.I.):*	**DOB:**	**Reference #**	**ID #**
Facility:		**Attending:**	
Admit Dx:			**Weight:**
Co-Morbidities:			
Admit Level of Care:	☐ Subacute ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Custodial		
Justification for Level:			
DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo			#hrs/month:
Current Barriers to DCP:			
Treatment Goals:			
Family Training Goals:			
Does Member Have an Advance Directive or Living Will? ☐ Yes ☐ No		**DPOA:**	**Phone Number:**
Does SNF Facility Provide Transportation? ☐ Yes ☐ No ☐ Other:			
Indicate Transportation Needs: ☐ O_2 ☐ Cane ☐ Gurney ☐ Wheelchair			

PATIENT SUPPORT/CAREGIVER

Name *(Last, First, M.I.):*		**Relationship:**
Address:		**Email:**
Party to Sign Contract:		
Home Number:	**Cell Number:**	**Work Number:**

PERSONAL SAFETY & ACTIVITY LEVEL

Resident Care Needs *(Check all conditions that apply):*
Dietary Requirements/Restrictions

☐ Chemo	☐ Eloper/ Wanderer	☐ Ileostomy	☐ O_2	☐ Trache	Wounds	☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/ Frequency:		☐ Venous	Stage(s):
☐ Dialysis/Days	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Personal Safety	Does Member have stairs at home?	☐ Yes	☐ No	How Many:	
	Does Member experience frequent falls?	☐ Yes	☐ No		
	Does Member have vision or hearing loss?	☐ Yes	☐ No	☐ Glasses	☐ Hearing Aids
	Indicate all appropriate assistive device(s) Member uses:	☐ Wheelchair	☐ Cane	☐ Walker	☐ Other
	• Ambulation x ft.	☐ Independent	☐ Max Assist	☐ Mod	☐ Min
	• Safety/Balance		☐ Good	☐ Fair	☐ Poor

Prior Level of Functioning:
Current Level of Functioning:
Discharge Plan:

MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY.

Name the Drug(s):	**Strength:**	**Frequency Taken:**

Date of Review _____ Nurse Reviewer Printed Name _____ Nurse Reviewer Signature _____ Contact Phone Number _____

SNF FOLLOW-UP REVIEW

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

Name *(Last, First, M.I.):*			**DOB:**	**Reference #**		**ID #**
Activity Level:						**Weight:**
DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo						#hrs/month:
Cognitive Status Alert/Oriented:	☐ x1	☐ x2	☐ x3	☐ x4		
Criteria Met for Continued Stay:	☐ Yes	☐ No	If yes, please describe deficit:			
Behavioral Change:	☐ Yes	☐ No	If yes, please describe:			
Dietary Change:	☐ Yes	☐ No	If yes, please describe:			
Medical Change:	☐ Yes	☐ No	If yes, please describe:			
Medication Change:	☐ Yes	☐ No	If yes, please describe:			
Skin Condition Change:	☐ Yes	☐ No	If yes, please describe:			
Any Falls Since Last Review:	☐ Yes	☐ No	If yes, please describe:			
Does SNF Facility Provide Transportation:	☐ Yes	☐ No	If no, please indicate needs:	☐ O_2	☐ Cane ☐ Gurney	☐ Wheelchair

CONTINUED CARE NEEDS

Resident Care Needs *(Check all conditions that apply):*

☐ Chemo	☐ Eloper/ Wanderer	☐ Ileostomy	☐ O_2	☐ Trache	**Wounds**	☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/ Frequency:		☐ Venous	Stage(s):
☐ Dialysis	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Activity Level	Bed Mobility	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Supine to Sit	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Sit to Supine	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent

Indicate all appropriate assistive device(s) Member uses:			☐ Wheelchair	☐ Cane	☐ Walker	☐ Other
• Gait Distance	x	ft.				
• Wheelchair Mobility	x	ft.	☐ Min	☐ Mod	☐ Max Assist	☐ Independent
• Safety/Balance	☐ Good	☐ Fair	☐ Poor			
• Endurance	☐ Good	☐ Fair	☐ Poor			
• Dressing Upper Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Dressing Lower Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Toileting	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Bathing	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Personal Hygiene	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		

Treatment Goals Set:

Treatment Goals Met:

Comments/Other (e.g. Specialty Consultation):

Updates to Discharge Plan:

Date of Review | Nurse Reviewer Printed Name | Nurse Reviewer Signature | Contact Phone Number

Service Request Template

Date: _____

Member Name: _____ ID# _____

Requesting Provider: _____ Telephone: _____

Servicing Provider: _____ MD NPI# _____

Address: _____ Telephone: _____

Requested Service: _____

ICD-10/Diagnosis Code(s): _____ (Pertaining to Requested Services)

CPT/Procedure Code:_____ (Pls call MD office to obtain correct codes)

Add'l CPT/Procedure Code: _____

Note:

Please attach **MD order, facesheet, and any other pertinent information related to services request.**

To expedite approval/denial, please fill in all areas completely and attach all needed documents.

Please contact IEHP LTC Case Manager or Coordinator assigned to your facility with any questions or concerns. Thank you.

REVISED 6/2017

□ Clinical Notes Attached

Wound Assessment - Admission

Member Name:	**ID:**	**Date:**	**Facility:**

1. Admitting Diagnoses:	**6. Wound #1**
□	**Type:** □ Surgical □ Arterial □ Venous
□	□ Pressure □ Foot wound □ Trauma
□	□
2. Comorbidities	**Location:**
□ History of Pressure Ulcers	□ Over bony prominences
□ History of Amputation	□ Under a Medical device (e.g. 02 mask, tubing)
□ History of Vascular Disease	□ Site of previously healed ulcer?
□ Diabetes Alc result: Date:	**Dimensions:**_____ Granulation_____% Eschar_____% Necrosis_____%
□ HTN	Slough_____% Undermining_____% Tunneling_____%
□ Renal failure □ On Dialysis	Stage: 1 2 3 4
□ Paralysis	Pain: 1 2 3 4 5 6 7 8 9 10
	Wound Culture:
	Source:
3. Functional Status	Date Collected:
□ Bed Bound □ Chair Bound	***Attach Report**
□ Ambulatory	**Imaging**
□ Structure Risk Assessment used to identify patient at risk for pressure ulcers? □Yes □No	Area:
4. Nutrition/Hydration Status	□ Xray □ U/S □ CT □ MRI
Oral Intake □ Good □ Fair □ Poor	
TPN Intake □ Yes □ No	***Attach Report**
Enteral Intake □ Yes □ No	**Antibiotic treatment**
If intake is fair-poor has a nutrition/education referral been made? □ Yes □ No If so when?	□ **Current**
Labs: □ Albumin □ Pre-Albumin □ Hgb	□ **Past** (med and dates given, PO vs. IV)
Date: Results:	**7. Patient Factors**
Nutritional supplement used:	
5. Physical Supports	Smoker? □ Yes □ No If yes, were tobacco cessation services offered? □ Yes □ No
Special mattress used? □ Yes □ No	Substance abuse? □ Yes □ No If yes, was rehab offered? □ Yes □ No
Incontinence pad needed? □ Yes □ No	□ Member, caregiver educated about pressure ulcer prevention and management? □ Yes □ No
Offloading devices used? □ Yes □ No	
Chair pressure reduction cushion used? □ Yes □ No	
Support surfaces/devices needed:	

□ Clinical Notes Attached

Wound Assessment – Follow up

Member Name:	**ID:**	**Date:**	**Facility:**

1. Functional Status	**Location:**
□ Bedbound □ Chairbound	□ Over bony prominences
□ Ambulatory	□ Under a medical device (e.g. 02 mask, tubing)
Structural risk assessment used to identify patients at risk for pressure ulcers? □ Yes □ No	□ Site of previously healed ulcer?
2. Nutrition/Hydration Status	**Dimensions:** _____ Granulation_____% Eschar_____% Necrosis_____%
Oral Intake □ Good □ Fair □ Poor	Slough_____% Undermining_____% Tunneling_____%
TPN Intake □ Yes □ No	Stage: 1 2 3 4 Improved? □ Yes □ No
Enteral Intake □ Yes □ No	If no, plan changes? □ Yes □ No
If intake is fair-poor has a nutrition/education referral been made? □ Yes □ No If so when?	□ Antibiotic started or changed
Labs: □ Albumin □ Pre-Albumin □ Hgb	□ Referred to wound care
Date: Results:	□ Referred to infectious disease
Nutritional supplement used:	□ Referred to vascular surgery
3. Wound #1 Follow up	□ Other (list)
Type: □ Surgical □ Arterial □ Venous	□ Attach follow up culture or imaging
□ Foot Wound □ Pressure □ Trauma	Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:
□	**5. Wound #3 Follow up**
Location:	**Type:** □ Surgical □ Arterial □ Venous
□ Over bony prominences	□ Foot Wound □ Pressure □ Trauma
□ Under a medical device (e.g. 02 mask, tubing)	□
□ Site of previously healed ulcer?	**Location:**
Dimensions:_____ Granulation_____% Eschar_____% Necrosis_____%	□ Over bony prominences □ Under a medical device (e.g. 02 mask, tubing)
Slough_____% Undermining_____% Tunneling_____%	□ Site of previously healed ulcer?
Stage: 1 2 3 4 Improved? □ Yes □ No	**Dimensions:** _____
If no, plan changes? □ Yes □ No	Granulation_____% Eschar_____% Necrosis_____%
□ Antibiotic started or changed	Slough_____% Undermining_____% Tunneling_____%
□ Referred to wound care	Stage: 1 2 3 4 Improved? □ Yes □ No
□ Referred to infectious disease	If no, plan changes? □ Yes □ No
□ Referred to vascular surgery	□ Antibiotic started or changed
□ Other (list)	□ Referred to wound care
□ Attach follow up culture or imaging	□ Referred to infectious disease
Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:	□ Referred to vascular surgery
4. Wound #2 Follow up	□ Other (list)
Type: □ Surgical □ Arterial □ Venous	□ Attach follow up culture or imaging
□ Foot Wound □ Pressure □ Trauma	Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:
□	

□ Clinical Notes Attached

Wound Assessment Addendum (6 or more wounds)

Member Name:	**ID:**	**Date:**	**Facility:**

1. Wound #_____Follow up	**3. Wound #____ Follow up**
Type: □ Surgical □ Arterial □ Venous	**Type:** □ Surgical □ Arterial □ Venous
□ Foot Wound □ Pressure □ Trauma	□ Foot Wound □ Pressure □ Trauma
Location:	**Location:**
□ Over bony prominences	□ Over bony prominences
□ Under a medical device (e.g. 02 mask, tubing)	□ Under a medical device (e.g. 02 mask, tubing)
□ Site of previously healed ulcer?	□ Site of previously healed ulcer?
Dimensions: _____ Granulation_____% Eschar_____% Necrosis_____%	**Dimensions:** _____ Granulation_____% Eschar_____% Necrosis_____%
Slough_____**%** Undermining_____**%** Tunneling_____%	Slough_____**%** Undermining_____**%** Tunneling_____%
Stage: 1 2 3 4 Improved? □ Yes □ No	Stage: 1 2 3 4 Improved? □ Yes □ No
If no, plan changes? □ Yes □ No	If no, plan changes? □ Yes □ No
□ Antibiotic started or changed	□ Antibiotic started or changed
□ Referred to wound care	□ Referred to wound care
□ Referred to infectious disease	□ Referred to infectious disease
□ Referred to vascular surgery	□ Referred to vascular surgery
□ Other (list)	□ Other (list)
□ Attach follow up culture or imaging	□ Attach follow up culture or imaging
Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:	Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:
2. Wound #____ Follow up	**4. Wound #____ Follow up**
Type: □ Surgical □ Arterial □ Venous	**Type:** □ Surgical □ Arterial □ Venous
□ Foot Wound □ Pressure □ Trauma	□ Foot Wound □ Pressure □ Trauma
□	□
Location:	**Location:**
□ Over bony prominences	□ Over bony prominences
□ Under a medical device (e.g. 02 mask, tubing)	□ Under a medical device (e.g. 02 mask, tubing)
□ Site of previously healed ulcer?	□ Site of previously healed ulcer?
Dimensions: _____ Granulation_____% Eschar_____% Necrosis_____%	**Dimensions:** _____ Granulation_____% Eschar_____% Necrosis_____%
Slough_____% Undermining_____% Tunneling_____%	Slough_____% Undermining_____% Tunneling_____%
Stage: 1 2 3 4 Improved? □ Yes □ No	Stage: 1 2 3 4 Improved? □ Yes □ No
If no, plan changes? □ Yes □ No	If no, plan changes? □ Yes □ No
□ Antibiotic started or changed	□ Antibiotic started or changed
□ Referred to wound care	□ Referred to wound care
□ Referred to infectious disease	□ Referred to infectious disease
□ Referred to vascular surgery	□ Referred to vascular surgery
□ Other (list)	□ Other (list)
□ Attach follow up culture or imaging	□ Attach follow up culture or imaging
Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:	Pain: 1 2 3 4 5 6 7 8 9 10 Improved? □ Yes □ No Plan:

INLAND EMPIRE HEALTH PLAN

Transportation Request Form (SNF & LTC)

TODAYS DATE: _____ *** IEHP ID#:** _____

*** NAME:** _____

Member Height: _____ **Member Weight:** _____

(Height & Weight needed only if Member is going by Wheelchair/ Gurney)

SPECIAL NEEDS: ☐ Trach to Ventilator; **Suctioning**: ☐ Deep ☐ Mild ☐ Shallow

Oxygen: ☐ Yes ☐ No Liter Flow: _____ **Comments** *(if any)*: _____

*** TRANSPORTATION FROM:**

Facility: _____ Room #: _____

Address: _____

City: _____ Zip: _____

Contact Person: _____ Phone #: _____

TRANSPORTATION TO:

* Dr. Name/Facility: _____ Room #: _____

* Address: _____ Phone #: _____

* City: _____ * Zip: _____

APPOINTMENT: (Please send request within Five (5) Business Days of appointment date)

* Appointment Date: _____ Dialysis Days: _____

* Appointment Time: _____ Start Date: _____

Chair Times: _____

*** TRANSPORT BY:**

☐ AMBULATORY

☐ WHEELCHAIR: ☐ Facility to provide wheelchair ☐ Vendor to provide wheelchair

☐ Bariatric ☐ Standard Wheelchair ☐ Wide Wheelchair ☐ Electric Wheelchair

☐ GURNEY:

☐ ALS ☐ BLS ☐ CCT ☐ Bariatric

☐ ATTENDANT/CAREGIVER

*** Denotes Required Field *****

Reminder: If Member is Dual Choice, transportation can be set up with ALC (American Logistics Company) phone #: (866) 880-3654. If ALC informs you that Member has exhausted their benefits, please fax request to **IEHP UM Transportation Department (909) 912-1049 within five (5) business days**. Thank you!

P.O BOX 1800 Rancho Cucamonga CA 91729-1800
Phone: (909) 890-2000 Fax: (909) 912-1049
Visit our web site at: www.iehp.org
A Public Entity

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