Geisinger Health Plan

Medical Concurrent Review Form
Fax to 570-953-0368 ATTN: SNF Case Managers

Member Name: _____ **Name of SNF:** _____

Member ID #: _____ **Date of Admit to SNF:** _____

Member DOB: _____ **Attending MD in SNF:** _____

DATE	*(Fill in each week)*			
COGNITIVE / BEHAVIORAL ISSUES				
RESPIRATORY	**O2 /BiPap/Cpap/VENT**			
	Sats			
	Breath sounds			
CARDIAC	**Edema**			
	Weight (if CHF)			
GI	**Diet**			
	%of PO intake			
	Supplements			
	N/V/D			
	Tube Feeding: Type			
	Formula & Rate			
	Weight			
IV	**TPN/rate**			
	Peripheral, PICC, Central Line			
	IV Med (s) /Frequency			
GU	**Bowel/ Bladder/ Ostomy**			
SKIN INTEGRITY	**Intact**			
	Wound Type: Pressure/ Vascular / Incision			
	Location			
	Stage			
	Measurement/LxWxD			
	Tunneling/ Undermining			
	Description			
	Treatment			
	Wound Vac			
ANY FALLS?	**Yes or No**			
	Date of fall			
	Injury			
PAIN	**Location**			
	Intervention			
	Effectiveness			
FSBS RANGES				
TREATMENT FOR INFECTION?	**Yes or No / List Med**			
	Source of Infection			
ANTICOAGULATION THERAPY?	**Yes or No / List Med**			
HEMODYNAMICALLY / MEDICALLY STABLE?	**Yes or No**			
EDUCATION				

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IF REQUESTING ANY LEVEL OTHER THAN LEVEL 1, PLEASE NOTE HERE AND SEND SUPPORTING DOCUMENTATION WITH THIS CONCURRENT REVIEW:	
ADDITIONAL COMMENTS:	

Geisinger Health Plan

Therapy Concurrent Review Form
Fax to 570-953-0368 ATTN: SNF Case Managers

Member Name: _____ **Name of SNF:** _____

Member ID #: _____ **Date of Admit to SNF:** _____

Member DOB: _____ **Attending MD in SNF:** _____

	GOALS (List Below):	***DATE (Fill in each week):***			
Date PT Eval Completed:			**PHYSICAL THERAPY**		
GAIT		**Weight Bearing**			
		Distance			
		Assistive Device			
		Level of Assist			
		Cues			
		Stairs			
TRANSFERS		**Sit to Stand**			
ENDURANCE					
BALANCE		**Sitting**			
		Standing			
Date OT Eval Completed:			**OCCUPATIONAL THERAPY**		
DRESSING		**Upper Body**			
		Lower Body			
BATHING		**Upper Body**			
		Lower Body			
BED MOBILITY		**Sit to Supine**			
		Supine to Sit			
SELF FEEDING					
TOILETING					
HOME EVAL					
Date ST Eval Completed:			**SPEECH THERAPY**		
SPEECH		**Dysphagia**			
		Diet & Liquids			
		Communication			
COGNITION					
THERAPY EDUCATION					
IF REQUESTING ANY LEVEL OTHER THAN LEVEL 1, PLEASE NOTE HERE AND SEND SUPPORTING DOCUMENTATION WITH THIS CONCURRENT REVIEW:					
Additional comments:					

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SNF Therapy Treatment Minute Log

Member Name: _____ ID #: _____ SNF Name: _____

****Initial Therapy evaluations are not to be included on this Treatment Log**

Date																									
Day #		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
PT	**I**																									
	C																									
	G																									
OT	**I**																									
	C																									
	G																									
ST	**I**																									
	C																									
	G																									
Daily Total																										
Level																										

Date																									
Day #		26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
PT	**I**																									
	C																									
	G																									
OT	**I**																									
	C																									
	G																									
ST	**I**																									
	C																									
	G																									
Daily Total																										
Level																										

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Member Name: ID #: SNF Name:

Date																								
Day #		51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
PT	**I**																									
	C																									
	G																									
OT	**I**																									
	C																									
	G																									
ST	**I**																									
	C																									
	G																									
Daily Total																										
Level																										

Date																								
Day #		76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
PT	**I**																									
	C																									
	G																									
OT	**I**																									
	C																									
	G																									
ST	**I**																									
	C																									
	G																									
Daily Total																										
Level																										

*Required Information. Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.