

## SKILLED NURSING FACILITY PRE-CERT WORKSHEET

## PLEASE FILL OUT COMPLETELY

Fax completed form (3 pages) to 570-953-0368ATTN: SNF Case Managers

PLEASE <u>PRINT</u> LEGIBLY – USE ONLY STANDARD ABBREVIATIONS WHERE NECESSARY									
Date of Admission to SNF:		SNF Name:							
Member Name:		SNF Fax #:							
GHP ID#:		Member DOB:							
Other Insurance Info:									
PRE-ADMISSION INFORMATION									
Diagnosis:	Diagnosis: ICD#:								
Additional Current									
Diagnoses:									
Pertinent PMH: ☐ CAD ☐ CHF ☐ COPD ☐ CVA ☐ DM ☐ DJD ☐ HTN ☐ PVD ☐ ESRD ☐ Dementia									
☐ Other (please specify)									
_	_	_	_						
Past Surgical History:   Amp	utation 🗌 CABG 🔃 Joint Rep	lacement 🗌 Spir	al Other						
Prior Level of Function:									
Patient Lives: Alone	With Spouse PCH/ALF	☐ ICF ☐ Other							
Home: Levels	Steps Bedroom on	Floor Bath	room on Floor						
	Home: Levels Steps Bedroom onFloor Bathroom on Floor Spouse/Other Able to Care for Member at Home:   Yes No If other, please identify								
opouse/other Abic to Gare for	Member at Florite.   Tes 140	ii otiici, picase ideii							
Services Requested:   OT   ST   RT   Skilled Nursing									
Decreased and News (Discourse)	and the arthur Ar								
Requestor's Name (Please pri	nt legibly):		·						
Requestor's Phone Number: _( Requestor's Fax Number: _()									
Requestor's Signature: Date:									

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MEDICAL STATUS Member Name:	
DATE FORM COMPLETED:	REMARKS:
Mental Status:	
Alert:	
Oriented:	
Follows Commands:	
Tube Feedings:	
Peg: J. Tube: Date Placed:	
Bowel/Bladder:	
Ostomy: Yes or No Type:	
Approx. Date of Ostomy:	
Foley or Straight Cath:	
Weight (in pounds): Height:	
Skin Integrity:	
Intact:	
Wound Care:	
Decubitus:	
Surgical:	
Respiratory:	
O2:	
Vent:	
C-PAP/BiPAP:	
Trach:	
Suctioning:	
Treatments:	
Medications:	
IV Med:	
Via: Frequency:	
Pain Management:	
Specialty Equipment Needs:	
Medically Stable/Hemodynamically Stable: Yes: ☐ No: ☐	
If yes, please explain below:	

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Independent WHAT DATE WAS THE FOLLOWING INFO PROVIDED BY THERAPY:  Bed Mobility: Supine – Sit  Transfer: Bed (Sit – Stand) Tollet TX  Ambulation: Weight Bearing Status Distance (in Feet) Assistive Device Amount of Assistance Stairs  Balance: Standing Sitting ADL Status: Self Feeding Grooming Upper Extremity Dressing Tolleting Upper Extremity Dressing Tolleting Lower Extremity Bathing Lower Extremity Bathing Lower Extremity Bathing Adaptive Equipment Orthotic/Prosthetic  Speech Therapy Dysphagia Diet Communication	FUNCTIO	NAL STAT	TUS .	Mem	ber Name:				
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