

Rehabilitation Assessment Form



Complete this form and fax it to **877-218-9089**. Include hospital admission H&P and any PM&R consultation notes.

Section 1 – Assessment Type/Coverage

Assessment Type: Initial Assessment Reassessment
Plan: Blue Medicare Advantage (PPO) Blue Medicare Advantage Comprehensive (PPO)

Section 2 – Member/Facility Information

Member Name _____ Age _____ Authorization Number _____
Contract Number _____ Facility Reviewer for Updates _____
Admitting Facility & NPI _____ Phone Number (____) _____ - _____ Fax Number (____) _____ - _____
Admission Type: SNF IP Rehab
Team Conference Day _____

Section 3 – Admission Information (Complete this section for the initial assessment only)

Admission Date (Facility) ____/____/____
Facility Doctor Name (First and Last Name) & NPI _____
ICD-10 Code _____ PMH _____
PSH _____ Height _____ Weight _____
Prior Level of Function (Home) _____
Home Configuration _____
Number of Steps at Entry _____
Location of Bed _____ Location of Bath _____

Section 4 – Clinical Information/Basics

Vital Signs: T _____ P _____ R _____ BP _____
Cognition/A&O: x1 x2 x3
Bowel: Continent Incontinent Ostomy
Bladder: Continent Incontinent Cath _____
Diet: NPO or _____
Tube Feeding: Formula _____
O2 Delivery: _____ Sats _____
Respiratory Tx: Yes No
Trach: _____ Size _____
Suction Frequency/24H: _____
Pain Location/Mgt: _____

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Section 5 – Mobility Current Functioning (Use Key in Section 11)

Bed Mobility: _____ Number of stairs: _____
Transfers: _____ Handrails: _____
Gait/Distance: _____ Assist needed: _____
Assist Level: _____ WC Mobility: _____
Assistive Device: None or _____
Type Distance: _____
Assist needed: _____
Stairs (ascending, descending):
 Not applicable Assist needed _____
Type

Section 6 – Clinical Information/Medications

IV medications, with ending dates: _____ Vascular Access: _____

Significant medications that affect functioning:

Section 7 – Self-Care Current Functioning (Use Key in Section 11)

Feeding: _____ Toileting/Hygiene Mgt: _____
Grooming: _____ ADL Transfers: _____
Bathing: _____ UE _____ LE _____
Comments: _____
Dressing: _____ UE _____ LE _____

Section 8 – Clinical Information/Skin Status

Skin Status: Intact
If not intact, complete fields below and add pages as needed.
Wound or Incision/Location 1 – Stage: _____ Wound or Incision/Location 2 – Stage: _____
Size (L x W x D in cm): _____ Size (L x W x D in cm): _____
Treatment: _____ Treatment: _____

Section 9 – Speech Therapy Current Status

None Results/Aspiration Risk/Recommendations:
 Dysphagia Eval./Modified Barium Swallow _____

Please continue on the next page.

Section 10 – Discharge (D/C) Plans

____/____/____
D/C Date (Tentative)

D/C with: HHC Provider _____
 OP Provider _____

D/C Equipment (prior auth required):

D/C Destination: _____

Member to live with: _____

Supervision Needs:

D/C Goals:

Section 11 – Key for Mobility and Self-Care Functioning

I	Independent
MI	Modified Independent
Sup	Supervision
SBA	Standby Assist
CGA	Contact Guard Assist

Min	Minimal
Mod	Moderate
Max	Maximum
Total	Total Assist

Section 12 – Additional Notes

Complete this form and fax it to **866-809-1370**. Include hospital admission H&P and any PM&R consultation notes.

Member Name _____

Contract Number _____

Admitting Facility _____

____/____/____
Today's Date