

Initial or CCR Review Form SNF/Subacute/Rehab/LTACH



Completion of the form must be accompanied by the **last three (3) days** only of supporting clinical documentation.
Fax: 617-897-0892

Section A. Member information	
Member Name:	Date of Birth (mm/dd/yyyy):
ID Number:	Date of Notification (mm/dd/yyyy):
Section B. Facility information	
Facility Receiving:	
Address:	Facility NPI:
Facility Phone:	Facility Fax:
Received from (facility/home/other):	
Place of Service Requested: <input type="checkbox"/> SNF <input type="checkbox"/> Sub-Acute Rehab <input type="checkbox"/> Acute Rehab <input type="checkbox"/> LTACH <input type="checkbox"/> IRF <input type="checkbox"/> Custodial	
Level of Care Requested:	
Section C. Admission information	
Diagnosis:	
Diagnosis Code(s):	
Review of Acute Care Admission:	
PMH:	
Social History:	
Section D. Contact information	
Facility Anticipated/Actual Admit Date:	
Facility Case Manager:	
Facility Case Manager Phone:	Facility Case Manager Fax:
Section E. Concurrent review information	
Last Covered Day:	
Ongoing Level of Care Request: <input type="checkbox"/> SNF <input type="checkbox"/> Sub-Acute Rehab <input type="checkbox"/> Acute Rehab/IRF <input type="checkbox"/> LTACH <input type="checkbox"/> Custodial	
Additional Comments:	
Section F. Current clinical status/treatment (may attach additional information if applicable)	
Mental Status: <input type="checkbox"/> AA&O <input type="checkbox"/> Confused <input type="checkbox"/> Sundowner	
Pain ___/10	Pain Location (specify):
Able to Participate in Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, (specify):	
O ₂ Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (specify O ₂ liters):	
Trach: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify date trach placed):	
Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify settings and weaning plan/attempts):	
Suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify needed frequency):	
Wound Management: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify location[s], stage, treatment):	
Tube Feeding (Enteral Feeds): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify):	
TPN/PPN: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify):	
IV Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify name, frequency, duration):	
Lab Monitoring: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify):	

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Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify peritoneal or HD and weekly schedule):							
Mobility Assistance: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Contact Guard <input type="checkbox"/> Min Asst <input type="checkbox"/> Max Asst <input type="checkbox"/> Total Asst							
ADL: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Contact Guard <input type="checkbox"/> Min Asst <input type="checkbox"/> Max Asst <input type="checkbox"/> Total Asst							
Speech Therapy Needs: Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify): Swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify): Cognition: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, (specify):							
Mobility Distance: <input type="checkbox"/> N/A <input type="checkbox"/> (Specify feet):							
Mobility Endurance: <input type="checkbox"/> N/A <input type="checkbox"/> Distance (Specify feet):							
Mobility with Device: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches Other (specify):							
Other, please specify:							
Section G. Current level of function/treatment							
	Independent	Supervision	Contact Guard	Min Asst	Mod Asst	Max Asst	Independent
ADL							
Bed Mobility							
Transfers							
Ambulation							
Section H. Prior home environment							
Prior Environment Status: <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Significant Other/Spouse <input type="checkbox"/> Lives with Others <input type="checkbox"/> Homeless							
Other, please specify:							
Number of Levels at Home:				Elevator Access? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of Stairs to Enter Home:				Ramp Access? <input type="checkbox"/> Yes <input type="checkbox"/> No Rails? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of Interior Stairs:				Ramp Access? <input type="checkbox"/> Yes <input type="checkbox"/> No Rails? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Bathroom Location: <input type="checkbox"/> 1st Floor <input type="checkbox"/> 2nd Floor <input type="checkbox"/> 3rd Floor <input type="checkbox"/> Other, please specify:							
Bedroom Location: <input type="checkbox"/> 1st Floor <input type="checkbox"/> 2nd Floor <input type="checkbox"/> 3rd Floor <input type="checkbox"/> Other, please specify:							
Support Hours/Day Available:							
Provided by (Informal Support):							
Paid Formal Support <input type="checkbox"/> Yes <input type="checkbox"/> No							
Are Services Resuming? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (specify, Service and Name of Organization):							
Current Home Equipment:							
Community Supports: <input type="checkbox"/> Transportation <input type="checkbox"/> Shopping <input type="checkbox"/> Laundry <input type="checkbox"/> Meals							
Section I. Discharge plan/goals							
Discharge Plan and Goal:							
Expected Discharge Date:							
Caregiver Available: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Caregiver contact information:							
Member on target for expected discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?							
Social Barriers/Psychosocial Issues:							
Potential Barriers to Discharge:							