SNF / Acute Rehab Admission Review

Fax: 508-368-9844

Patient name: ______________________________ DOB: ____________ DOA: _______

Referring MD: ______________________________ Telephone: ___________________________

PCP: ___________________________________ Telephone: ___________________________

Facility: ______________________ Contact: _____________________ Phone: _________________

Patient's next of kin: _________________________ Home phone: _________________________

Address: __________________________________ Work phone: _________________________

____

Is next of kin: **HCP**: ☐ Yes ☐ No **POA**: ☐ Yes ☐ No

Admitting diagnosis: _________________________ Cognitive status: current________________

Patient admitted from: _________________ Prior to admission: _____________________Functional status prior to admission: ☐ NH Resident Assisted living ☐ Independent ☐ Dependent ☐ Lived alone ☐ Lives with significant other

Any assistive devices? ____

Social history: Specify supports, primary caregiver and community services prior to admission: __________________

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Past medical history: ____

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Brief history of present illness: Please include all diagnosis, surgeries with date of service, current medications, IV's, respiratory status, and pain management: ____

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Key: 1 – Independent **2** – Supervision **3** – Contact guard **4** – Minimum assist **5** – Moderate assist **6** – Maximum assist **7** – Dependent

Bed Mobility ________	Ambulation _________	Feeding: ____________
Transfers: ___________	Device: _____________	Bathing UE __________
Dressing LE: _________	Endurance: ___________	Bathing LE __________
Dressing UE: _________	Distance: ____________	Toileting: ____________

Estimated LOS: ____________________ Potential barriers to D/C: ______________________________

Expected Discharge Site: ☐ Home ☐ LTP ☐ Assisted Living ☐ Rest Home

Primary Caregiver: ____________________________________ ______________________________

(Signature of the Licensed Staff person completing form)