Skilled Nursing Facility / Acute Rehab
Request for Continued Stay

Fallon case manager: ________________________ Fax: 508-368-9844

Member: ____ Referral Number: ___________________

Facility: ______________________ Contact: ______________________ Phone: _________________

Attending physician: ______________________________ Phone: _________________

______________ (Admission date) ________________________ (Current authorization expires) ________________ (Date of this request) ______________________ (Discharge Date (if applicable))

Qualifiers	Frequency	Description	D/C Date
IV Fluids (IVF)/Rate			
SQ/IM/IV Meds/Dose			
Med changes			
Tube feedings/TPN Rate			
Wound management/Other			
Wound size			
Vent			
Trach			

	Frequency	D/C Date		Frequency	D/C Date		Frequency	D/C Date
PT			OT			ST		

Transfers		Transfers			Assistance Key
Sit – Stand		Bed – Chair		I	Independent
Toilet				Mod 1	Modified Independent
ADL's				Mod	Mod/Extensive assistance
Feeding		Toileting		S	Supervision
Bathing UE LE		Dressing UE LE		Min	Minimum/Limited Assistance
Tub/Shower		Bed Mobility		Dep	Totally Dependent
Balance: Sitting Standing					
Ambulation					
Device – Rolling Walker (RW)		Distance/Level			
Stairs – Inside/Outside					

Please provide additional pertinent clinical information necessary to make level of care determination
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Discharge plan:

Barriers to Discharge: ____
Anticipated D/C date: ___________ Patient to be D/C to: ☐ LTC ☐ Home ☐ Lives alone ☐ With significant other
Anticipated services needed at home: _____________________________ to be provided by: ___________________
Home evaluation: ____________________ Family meeting: ____________________ Teaching needs: ____________________

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Signature and title of licensed staff member completing this form

SNF request for continued stay 11/27/01