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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| iehphartLTC Follow-Up review | | | | | | | | | | | | | | | | | | | | | |
| Please fax completed form to your facility’s assigned IEHP Nurse.All questions contained in this questionnaire are strictly **confidential** and will become part of the Member’s medical record. | | | | | | | | | | | | | | | | | | | | | |
| Facility: | | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | | | | | | | DOB: | | | **Reference #** | | | | | ID # | | | | | |
| Activity Level: Height: | | | | | | | | | | | | | | | | **Weight:** | | | | | |
| **DCP:** 🞎 LTC 🞎 B&C 🞎 Home 🞎 Home with HH 🞎 Home with CBAS 🞎 Home with IHSS/hr/mo | | | | | | | | | | | | | | #hrs/month: | | | | | | | |
| **Cognitive Status Alert/Oriented:** | | | | | 🞎 x1 | 🞎 x2 | | 🞎 x3 | 🞎 x4 | | | | | | | | | | | | |
| **Criteria Met for Continued Stay:** | | | | | 🞎 Yes | 🞎 No | | If yes, please describe deficit: | | | | | | | | | | | | | |
| **Behavioral Change:** | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| Dietary Change: | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| Medical Change: | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| **Medication Change:** | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| **Skin Condition Change:** | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| **Any Falls Since Last Review:** | | | | | 🞎 Yes | 🞎 No | | If yes, please describe: | | | | | | | | | | | | | |
| Does SNF Facility Provide Transportation?: | | | | | | 🞎 Yes | 🞎 No | If no, please indicate needs: | | | | | 🞎 O2 🞎 Cane 🞎 Gurney 🞎 Wheelchair | | | | | | | | |
| continued care needs | | | | | | | | | | | | | | | | | | | | | |
| Resident Care Needs (Check all conditions that apply): | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | |  | |  | | | | |
| 🞎 Chemo | | 🞎 Eloper/  Wanderer | 🞎 Ileostomy | | | 🞎 O2 | | 🞎 Trach | | | | **Wounds** | | | 🞎 Surgical | | 🞎 Pressure | | | | |
| 🞎 Colostomy | | 🞎 Foley Cath | 🞎 Isolation | | | 🞎 Smoker | | 🞎 Other: | |  | | 🞎 Arterial | | #: | | | |  |
|  | |  | | | |  |
| 🞎 Coma | | 🞎 G/J Tube | 🞎 NG Tube | | | 🞎 Radiation | | 🞎 Suctioning/  Frequency: | | | | 🞎 Venous | | Stage(s): | | | |  |
|  | | |  | |
| 🞎 Dialysis | | 🞎 HHN | 🞎 NPO | | | 🞎 TPN | |  | | | | 🞎 Foot Wounds | |  | | | | |
| Activity Level | | Bed Mobility | | 🞎 Max | | 🞎 Mod | | 🞎 Min | | | | 🞎 Assist | | | 🞎 Independent | |  |  | | | |
| Supine to Sit | | 🞎 Max | | 🞎 Mod | | 🞎 Min | | | | 🞎 Assist | | | 🞎 Independent | |  |  | | | |
| Sit to Supine | | 🞎 Max | | 🞎 Mod | | 🞎 Min | | | | 🞎 Assist | | | 🞎 Independent | |  | |  | | |
| Indicate all appropriate assistive device(s) Member uses: | | | | | | | | 🞎 Wheelchair | | | | 🞎 Cane | | | 🞎 Walker | | 🞎 Other | | | | |
|  | * Gait Distance | | | x | | ft. | |  | | | |  | | |  | |  | |  | | |
|  | * Wheelchair Mobility | | | x | | ft. | | 🞎 Min | | | | 🞎 Mod | | | 🞎 Max Assist | | 🞎 Independent | | | | |
|  | * Safety/Balance | | | 🞎 Good | | 🞎 Fair | | 🞎 Poor | | | |  | | |  | |  | | | | |
|  | * Endurance | | | 🞎 Good | | 🞎 Fair | | 🞎 Poor | | | |  | | |  | |  | | | | |
|  | * Dressing Upper Body | | | 🞎 Min | | 🞎 Mod | | 🞎 Max Assist | | | | 🞎 Independent | | |  | |  | | | | |
|  | * Dressing Lower Body | | | 🞎 Min | | 🞎 Mod | | 🞎 Max Assist | | | | 🞎 Independent | | |  | |  | | | | |
|  | * Toileting | | | 🞎 Min | | 🞎 Mod | | 🞎 Max Assist | | | | 🞎 Independent | | |  | |  | | | | |
|  | * Bathing | | | 🞎 Min | | 🞎 Mod | | 🞎 Max Assist | | | | 🞎 Independent | | |  | |  | | | | |
|  | * Personal Hygiene | | | 🞎 Min | | 🞎 Mod | | 🞎 Max Assist | | | | 🞎 Independent | | |  | |  | | | | |
| Treatment Goals Set: | | | | | | | | | | | | | | | | | | | | | |
| Treatment Goals Met: | | | | | | | | | | | | | | | | | | | | | |
| Comments/Other (e.g. Specialty Consultation): | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Updates to Discharge Plan: | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |

Date of Review Nurse Reviewer Printed Name Nurse Reviewer Signature Contact Phone Number