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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