SNF Clinical Request Form

TAR#

Fax: 805-681-3071



Member Name:	Facility name/NPI:		
Member ID: DOB:	Facility Tel/Fax:		
PASSR Submitted? Y/ N Date Submitted:	MDS Submitted? Y/ N Date Submitted:		
Primary Diagnosis: Past Medical Hx:			
Home Setting: (Community, Facility, Homeless)	# of Stairs to entry:		
Type of Home (e.g. LTC/House/Apt/Mobile):	W/C Ramp? Y/ N:		

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Occupational Therapy	Baseline	CLOF Date:	CLOF Date:	CLOF Date:	CLOF Date:		
Feeding							
Grooming							
Bathing							
Dressing – Upper							
Dressing – Lower							
Toileting/Hygiene							
Transfer – Toilet							
Transfer – Shower	- "						
Physical Therapy	Baseline	CLOF Date:	CLOF Date:	CLOF Date:	CLOF Date:		
Bed Mobility							
Transfer – Chair/WC							
Gait							
Distance (steps/feet)							
Assistive device? Type							
Stairs: # & assistance							
Wheelchair mobility							
Speech Therapy	Baseline	CLOF Date:	CLOF Date:	CLOF Date:	CLOF Date:		
Diet: Type/Enteral/%							
Cognition							
Memory							
Problem Solving							
Safety Awareness							
Skin Assessment	Date:	Date:	Date:	Date:	Date:		
Wound #1 Measurement:							
Wound #2 Measurement:							
Wound #3 Measurement:							
Wound #4 Measurement:							
Wound types/treatment plan:							
IV Infusions(Med/Frequency/Duration:							
IV Access Type/ Location:		Foley:	Drain:				
Anticipated DC date & plan:							
Barriers to DC plan:							
Anticipated New DME o	r Services need	ded at DC:					

To help us facilitate a timely decision, please submit recent physician notes/orders/60-day recert to CenCal Health.

Community resources the member has been referred to:

Notes: