SNF Clinical Request Form

CenCal HEALTH® Local. Quality. Healthcare.

Fax: 805-681-3071 **TAR #** _____

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)** **Type of Home (e.g. LTC/House/Apt/Mobile):**	**# of Stairs to entry:** **W/C Ramp?** ○ **Y/** ○ **N:**

Please include level of function status for each update: Ind | Mod I | Sup/SBA | Min A/CGA | Mod A | Max A | Total A

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 or Services needed at DC:

Community resources the member has been referred to:

Notes:

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