

Skilled Nursing Facility Review Form

This form is to assist skilled nursing facilities with providing clinical updates for CarePartners of Connecticut members. Please complete the form and fax to the appropriate care manager. A complete listing of care managers is available on the CarePartners of Connecticut website.

Today's Date: _____

Member Name: _____ Member ID#: _____ Date of Birth: _____

Facility: _____ Facility Care Manager: _____

Phone #: _____ Fax #: _____

Estimated length of stay: _____ **** PLEASE ATTACH MAR WITH FIRST REVIEW****

KEY

IND	SUPV
CG	MIN A
MOD A	MAX A
DEP	

Review #1 **Review #2** **Review #3** **Review #4**
 Date: _____ Date: _____ Date: _____ Date: _____

Gait			
Weight bearing			
Distance / AD			
Level of assist			
Stairs # / Rails			
Bed mobility			
Standing balance			
Transfers			
Activity TOL			
Bathing UB			
Bathing LB			
Dressing UB			
Dressing LB			
Toilet trans			
Toilet hygiene			
Cognition/Swallow			
HT / WT			
Resp / O2 / O2 sat			
Bowel / bladder			
Skin integrity			
Pain mgmt.: 0-10			
Medication Monitor / Change			

ADDITIONAL COMMENTS:

**** PLEASE USE A SEPARATE FORM FOR DISCHARGE PLANNING INFORMATION****

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