

Facility name / NPI:				Facility fax/phone number:			
Member name/ DOB:				Primary diagnosis:			
Admit date/authorization number:				Past medical history if H&P not attached:			
Prior level of functioning (PLOF):							
Home setting – e.g., LTC/House/Apt/Mobile Home:				Number of stairs in prior living environment:			
Weight-bearing restrictions:				F/U ortho or surgical appt. date:			
LEVELS	Comp I	Mod I	Supervision/ SBA	Min A/CGA	Mod A	Max A	Total A
OCCUPATIONAL THERAPY			Update/Date	Update/Date	Update/Date	Update/Date	Update/Date
Feeding							
Grooming							
Bathing							
Dressing – upper body							
Dressing – lower body							
Toileting/hygiene							
Transfer – toilet							
Transfer – tub/shower							
PHYSICAL THERAPY			Update/Date	Update/Date	Update/Date	Update/Date	Update/Date
Bed mobility							
Transfer – chair/WC							
Gait - distances/assist							
Assistive device? Y/N & type							
# of stairs & assistance needed?							
Wheelchair mobility							
SPEECH THERAPY			Update/Date	Update/Date	Update/Date	Update/Date	Update/Date
Diet Type/ enteral / %							
Cognition/level of orientation, e.g., confused, A&O x 3:							
Describe deficits r/t memory, problem solving, safety awareness:							
DISCHARGE PLANNING							
D/C Date & Plan:							
Psychosocial issues:							
Barriers to D/C plan:							
New DME needed at D/C?							
Is there a caregiver? Y/N			Days/week:			Hours/day:	
What type of caregiver education was provided?							