TUFTS Health Plan

Extended Care Inpatient Continued Stay Clinical Information Form – Initial

Member name: _____ Member ID#: _____ Date: _____

Facility: _____ Facility care manager: _____ Fax: _____

Tufts Health Plan care manager: _____ Fax: 617.972.9740 or 617.972.9741

Instructions: To be included in daily rounds, fax clinical information by 11 a.m. or no later than 5 p.m. one business day prior to the Authorized End Date.

Report progress utilizing FIM Score Key:

1 Total assist	5 Supervision
2 Max assist	6 Mod indep
3 Mod assist	7 Complete indep
4 Min assist	

INITIAL Authorized End Date:

PT: Barrier to discharge_____

_____

Home eval needed_____

Prior level of function_____

_____

Current home situation/support _____

_____

Weight bearing_____ Sit-Stand _____ Devices _____

Bed mobility _____ Bed-Chair _____ Distance_____

Sup-Sit _____ Ambulation _____ W/C _____

DME_____

Nursing Issues/Needs: Barrier to discharge_____

_____

O_2_____

_____

Skin/wound_____

_____

Pain_____

Bowel_____

Bladder_____

Safety _____

Nutrition _____

OT: Barrier to discharge _____

_____

Prior level of function _____

_____

UBB _____ UBD _____ Toilet/Commode _____ Transfers _____

LBB _____ LBD _____ Toilet Hygiene _____ IADLs _____

Adaptive equipment _____

ST: Concerns/Issues _____

_____

Communication _____

Cognition _____

Dysphagia _____

Notes _____

_____

WEEK # _____ **Authorized end date:** _____

Family/team meeting date _____

Meeting outcome/ongoing dialog: _____

_____

_____

PT: Discharge disposition/Home care services _____

_____

_____

Goals _____

_____

_____

DME _____

_____

Estimated length of stay _____

Weight bearing _____ Sit-Stand _____ Devices _____

Bed Mobility _____ Bed-Chair _____ Distance _____

Sup-Sit _____ Ambulation _____ W/C _____

Nursing Issues/Needs: Discharge disposition/home care services _____

_____

Goals _____

_____

Skin/wound _____

_____

Pain _____

Bowel _____

Bladder _____

Safety _____

Nutrition _____

OT: Discharge disposition/home care services _____

_____

_____

Goals _____

_____

_____

Adaptive equipment _____

_____

Estimated length of stay _____

UBB _____ UBD _____ Toilet/Commode _____ Transfers _____

LBB_____ LBD_____ Toilet/Hygiene _____

ST: Discharge disposition/home care services _____

_____

_____

Goals _____

_____

Adaptive equipment _____

Estimated length of stay _____

Communication _____

Cognition _____

Dysphagia _____

Notes _____

Provider Services