TUFTS Health Plan

Extended Care Inpatient Continued Stay Clinical Information Form – Additional

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

Facility: _____ Facility care manager: _____ Fax: _____

Tufts Health Plan care manager: _____ Fax: 617.972.9470

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	

Week # _____

Family/Team meeting date _____

Authorized end date _____

Meeting outcome/Ongoing dialogue:

_____

_____

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

_____

O_2_____

_____

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 _____

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

Family/Team meeting date: _____

Meeting outcome/Ongoing dialogue: _____

_____

_____

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 _____