



## 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:

Week # \_\_\_\_\_  
 Family/Team meeting date \_\_\_\_\_

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

Authorized end date \_\_\_\_\_

Meeting outcome/Ongoing dialogue:  
 \_\_\_\_\_  
 \_\_\_\_\_

<p><b>PT:</b> 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 _____</p>	<p><b>Nursing Issues/Needs:</b> Discharge disposition/Home care services _____          _____          _____          O<sub>2</sub> _____          _____          Skin/Wound _____          _____          Pain _____          Bowel _____          Bladder _____          Safety _____          Nutrition _____</p>
<p><b>OT:</b> Discharge disposition/Home care services _____          _____          _____          Goals _____          _____          _____          Adaptive equipment _____          _____          Estimated length of stay _____          UBB _____ UBD _____ Toilet/Commode _____ Transfers _____          LBB _____ LBD _____ Toilet/Hygiene _____</p>	<p><b>ST:</b> Discharge disposition/Home care services _____          _____          _____          Goals _____          _____          _____          Adaptive equipment _____          Estimated length of stay _____          Communication _____          Cognition _____          Dysphagia _____          Notes _____</p>

WEEK # \_\_\_\_\_ Authorized end date: \_\_\_\_\_  
 Family/Team meeting date: \_\_\_\_\_  
 Meeting outcome/Ongoing dialogue: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<p><b>PT:</b> 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 _____</p>	<p><b>Nursing Issues/Needs:</b> Discharge disposition/Home care services _____          _____          _____          Goals _____          _____          _____          Skin/wound _____          _____          Pain _____          Bowel _____          Bladder _____          Safety _____          Nutrition _____</p>
<p><b>OT:</b> Discharge disposition/Home care services _____          _____          _____          Goals _____          _____          _____          Adaptive equipment _____          _____          Estimated length of stay _____          UBB _____ UBD _____ Toilet/Commode _____ Transfers _____          LBB _____ LBD _____ Toilet/Hygiene _____</p>	<p><b>ST:</b> Discharge disposition/Home care services _____          _____          _____          Goals _____          _____          _____          Adaptive equipment _____          Estimated length of stay _____          Communication _____          Cognition _____          Dysphagia _____          Notes _____</p>

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