

Tufts Health Plan SNF Discharge Planning Form

This form is to assist providers with discharge planning for Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan members.

Today's date: _____

Member name: _____

Member ID#: _____ Date of birth: _____

Facility: _____

Facility care manager: _____

Phone #: _____

Fax #: _____

Name of discharge planner: _____

Phone #: _____

Anticipated discharge date: _____		
Stairs required for entry? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many stairs? _____
Discharge destination: <input type="checkbox"/> Home alone <input type="checkbox"/> Home with family/friends <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Custodial nursing home/LTC <input type="checkbox"/> Other: _____		Comments:
Skilled needs upon discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skilled nursing <input type="checkbox"/> Social worker <input type="checkbox"/> Physical therapy <input type="checkbox"/> Home health aide <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Speech therapy		Agency name: Comments:
Durable medical equipment evaluation/needs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Potential barriers (e.g., physical, environmental, family)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health care proxy/durable power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicaid application in process? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Medication review and reconciliation completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PLEASE ATTACH DISCHARGE MEDICATION LIST		
Follow-up Appointments		
<input type="checkbox"/> PCP	<input type="checkbox"/> Specialist	<input type="checkbox"/> Other
Name: _____	Name: _____	Name: _____
Date: _____	Date: _____	Date: _____
Time: _____	Time: _____	Time: _____

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