

Patient's current level of Care: (if in SNF now, please also indicate acute dates)

SNF Acute Acute Rehab Home Board & Care

SNF Dates _____ Acute Dates _____

Please confirm that the person being referred meets basic admission criteria

- Resident of City & County of San Francisco Yes No
- Primary diagnosis is a medical condition (not psychiatric) requiring Skilled Nursing Facility care (MD verified) Yes No
- Existing physical or cognitive functional limitations requiring care that cannot be provided at a lower level (e.g. B&C, intermediate facility) Yes No
- Requires active daily rehabilitation on an inpatient basis Yes No
- Need for ongoing rehabilitation aimed at improving functional status Yes No

PART B

Section 1 Patient Demographics

Name of Patient _____ Age _____

Birthdate _____ Sex _____ Race _____ Ethnicity _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Marital Status _____ Occupation _____

SS# _____ Birthplace _____ Religion _____

Primary Language _____ English Speaking Yes No Smoker Yes No

Nearest Relative _____ Relationship _____

Relative's Address _____ Phone _____

Emergency Contact _____ Phone _____

Is patient capable of making financial decisions? Yes No Unk

If patient becomes unable to make financial decisions please give name _____
 _____ and phone number _____ of designated financial decision maker

Is patient conserved? Yes No If yes, what type _____

Name of conservator _____ Phone _____

Section 2 Pre-Admission Financial Data

A. Government Benefits

Medicare: Part A effective date _____ Eligible Yes No
 Part B effective date _____ Number _____
 Part D, prescription Rx plan _____
 Is the patient enrolled in Medicare's hospice plan? Yes No

Medi-Cal:

Eligible Yes No
 Number _____ Effective Date _____
 Pending, Application Date _____
 Approved/effective Date _____

B. Private Insurance/HMO

Carrier Name _____ Policy/Group # _____
 Contact and Phone # _____
 Name of Insured _____ Union/Local (if applicable) _____

C. Income

Monthly Amount \$ _____ Source _____
 Monthly Amount \$ _____ Source _____
 Other (describe) _____

D. Assets

Cash on hand \$ _____ Bank Funds \$ _____
 Acct. Type(s) _____
 Bank(s) _____
 Securities (current value) _____
 Property:
 Location _____
 Assessed Value _____ Amount Owed _____
 Other (describe) _____

PART C**Section 1 Medical Diagnosis/SNF Need**

Diagnosis requiring SNF level of care: _____

Allergies _____

PICC _____

Wounds _____

Dressing Frequency _____

NGT/PEG/ J-tube Yes No Weight _____ Height _____

Special Equipment (e.g. CPAP, BiPAP, wound vac, etc): _____

Does he/she have own equipment and self-manages it outside acute care? _____

IV Antibiotics _____ Duration _____

Date last PPD _____ Results _____

Date last CXR _____ Results _____

Advance Directive or
Code Status: Full Code DNR/DNI Comfort Undetermined

Infections: VRE MRSA TB +PPD None

Where? _____

Treatment _____

Immunizations: pneumococcal vaccine Yes, Date _____ No

Influenza vaccine Yes, Date _____ No

Other: _____ Date _____

Section 2 Activities of Daily Living

Indicate appropriate Number next to activity

| | | |
|---------------------------------|-------|---------------------|
| 1= independent | _____ | walking |
| 2= assist with device | _____ | turning/positioning |
| 3=assist with person | _____ | transferring |
| 4=assist with person and device | _____ | bathing |
| 5= totally dependent | _____ | dressing |
| | _____ | feeding |
| | _____ | toileting |

Indicate Status:

| | | | |
|---|------------------------------------|---|------------------------------------|
| Bowel: <input type="checkbox"/> incontinent | <input type="checkbox"/> continent | Bladder: <input type="checkbox"/> incontinent | <input type="checkbox"/> continent |
| <input type="checkbox"/> colostomy | | <input type="checkbox"/> Foley catheter or suprapubic tube | |

Diet: _____

Section 3 Behavioral Issues

1. Criminal Hx: Yes No
 2. Possession/Use of weapons, illegal drugs or drug paraphernalia, drug trafficking? Yes No

Answer # 3, 4, 5, 6, 7 based upon behavior over the past 10 days:

3. Aggressive/Assaultive/Combative: Yes No
 4. Intrusive Behavior: Yes No
 5. Noisy/Disruptive: Yes No
 6. Elopement Risk Yes No
 7. Is patient dangerous to self or others Yes No
 8. Psychiatric Condition: Yes No
 Dx _____
 9. Suicidal Ideation Yes No
 Presently Yes No
 In the past Yes No
 10. Sexual Predation Yes No
 Registered sex offender Yes No

If yes to any above, state # and describe _____

11. Alcohol History: _____

12. Drug Abuse: Yes, type _____ No
 Currently using (at time of hospitalization): Yes No
 Past use: Yes No

13. Is patient on restraints? Yes, Type _____ No

14. Smoking History: _____

15. Unsafe smoker? Yes No

16. Does patient have a sitter? Yes, Reason _____ No

17. Are there (past or present) any legal charges for any above behaviors? Yes No

If yes, describe _____

Please note: ***For referrals from a hospital please attach the following***
 One week of current nursing notes and progress notes, list of medications, history and physical. For referral to Rehabilitation services, please submit most recent PT and OT notes.

Please complete **Part D** if referral is from Board and Care Facility or Home

1. For referrals from BOARD & CARE FACILITIES and HOME, part D portion must be completed by a physician or other clinician to assure accuracy and meet legal compliance. Please attach additional medical information if available

PART D

Medical Information Summary

Signature required whether Part D is completed or attachments are provided.

Patient Name _____

Primary Physician _____ Phone # _____

Physician Signature _____

Alternate Contact Person _____ Phone # _____

Summary of Medical Problems: _____

Past Medical History: _____

Previous Surgeries (Dates and location):

Disabilities (include sight, hearing, ambulation) _____

Current Medications: _____

Date of last physical and relevant Findings: _____
