

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: _____

DOB: _____

A. PATIENT INFORMATION

Gender: Male Female
 Hispanic Ethnicity: Yes No
 Race: White Black Other: _____
 Language: English Other: _____

B. SIGHT HEARING

Normal Impaired Normal Impaired
 Blind Deaf Hearing Aid L R

C. DECISION MAKING CAPACITY (PATIENT):

Capable to make healthcare decisions Requires a surrogate

D. EMERGENCY CONTACT

Name: _____ Name: _____
 Phone: _____ Phone: _____

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge:
 Reason for transfer (Brief Summary): _____

Surgical procedures performed during stay: None

Other diagnoses: _____

F. INFECTION CONTROL ISSUES

PPD Status: Positive Negative Not known
 Screening date: _____

Associated Infections/resistant organisms: _____

MRSA Site: _____
 VRE Site: _____
 ESBL Site: _____
 MIDRO Site: _____
 C-Diff Site: _____
 Other: Site: _____

Isolation Precautions: None

Contact Droplet Airborne

G. PATIENT RISK ALERTS

None Known Harm to self Difficulty swallowing
 Elopement Harm to others Seizures
 Pressure Ulcers Falls Other: _____

RESTRAINTS: Yes No

Types: _____

Reasons for use: _____

ALLERGIES: None Known Yes, List below:

Latex Allergy: Yes No Dye Allergy/Reaction: Yes No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	Yes	No
Living Will	Yes	No
DO NOT Resuscitate (DNR)	Yes	No
DO NOT Intubate	Yes	No
DO NOT Hospitalize	Yes	No
No Artificial Feeding	Yes	No
Hospice	Yes	No

I. TRANSFERRED FROM

Facility Name: _____
 Date: _____ Unit: _____
 Phone: _____ Fax: _____
 Discharge Nurse: _____
 Admit Date: _____ Discharge Date: _____
 Admit Time: _____ Discharge Time: _____

J. TRANSFERRED TO

Facility Name: _____
 Address 1: _____
 Address 2: _____
 Phone: _____ Fax: _____

K. PHYSICIAN CONTACTS

Primary Care Name: _____
 Phone: _____
 Hospitalist Name: _____
 Phone: _____

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
 Script sent for controlled substances (attached): Yes No

<input type="checkbox"/> Anticoagulants	Date: _____	Time: _____
<input type="checkbox"/> Antibiotics	Date: _____	Time: _____
<input type="checkbox"/> Insulin	Date: _____	Time: _____
<input type="checkbox"/> Other:	Date: _____	Time: _____

Has CHF diagnosis: Yes No

If yes; new/worsened CHF present on admission?
 Yes No

Last echocardiogram: Date: _____ LVEF %

On a proton pump inhibitor? Yes No

If yes, was it for: In-hospital prophylaxis and can be discontinued
 Specific diagnosis:

On one or more antibiotics? Yes No

If yes, specify reason(s): _____

Any critical lab or diagnostic test pending at the time of discharge? Yes No

If yes, please list: _____

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10): _____

Last administered: Date: _____ Time: _____

N. FOLLOWING REPORTS ATTACHED

<input type="checkbox"/> Physicians Orders	<input type="checkbox"/> Treatment Orders
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Includes Wound Care
<input type="checkbox"/> Medication Reconciliation	<input type="checkbox"/> Lab reports
<input type="checkbox"/> Discharge Medication List	<input type="checkbox"/> X-ray <input type="checkbox"/> EKG
<input type="checkbox"/> PASRR Forms	<input type="checkbox"/> CT Scan <input type="checkbox"/> MRI
<input type="checkbox"/> Social and Behavioral History	

ALL MEDICATIONS: (MAY ATTACH LIST)

Patient Name: _____

DOB: _____

O. VITAL SIGNS

Date: _____ Time Taken: _____
 HT: _____ WT: _____
 Temp: _____ BP: _____
 HR: _____ RR: _____ SpO2: _____

P. PATIENT HEALTH STATUS

Bladder: Continent Incontinent
 Ostomy Catheter Type: _____ date inserted: _____
 Foley Catheter: Yes No If yes, date inserted: _____
Indications for use:
 Urinary retention due to: _____
 Monitoring intake and output
 Skin Condition: _____
 Other: _____
Attempt to remove catheter made in hospital? Yes No
 Date Removed: _____
Bowel: Continent Incontinent Ostomy
 Date of Last BM: _____
Immunization status:
 Influenza: Yes No Date: _____
 Pneumococcal: Yes No Date: _____

Q. NUTRITION / HYDRATION

Dietary Instructions: _____
 Tube Feeding: G-tube J-tube PEG
 Insertion Date: _____
 Supplements (type): TPN Other Supplements: _____
 Eating: Self Assistance Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

PT - Frequency: _____
 OT - Frequency: _____
 Speech - Frequency: _____
 Dialysis - Frequency: _____

S. PHYSICAL FUNCTION

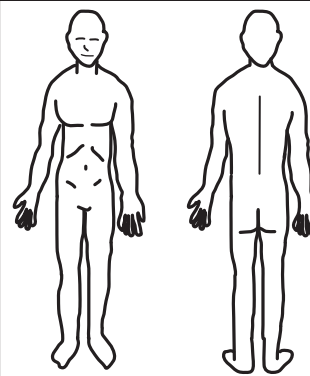
Ambulation: Not ambulatory Ambulates independently Ambulates with assistance Ambulates with assistive device	Transfer: Self Assistance 1 Assistant 2 Assistants
Devices: Wheelchair (type): Appliances: Prosthesis: Lifting Device:	Weight-bearing: Left: Full Partial None Right: Full Partial None

Y. PHYSICIAN CERTIFICATION

I certify the individual requires nursing facility (NF) services.
 The individual received care for this condition during hospitalization.
 I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Effective date of medical condition _____	Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physician/ARNP Signature: _____	Date: _____
Printed Physician/ARNP Name & Title: _____	Phone Number: _____
Person completing form: _____	Phone Number: _____ Date: _____

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers
 (Indicate stage and location(s) of lesions using corresponding number:
 1.
 2.
 3.
 List any other lesions or wounds: _____

U. MENTAL / COGNITIVE STATUS AT TRANSFER

Alert, oriented, follows instructions
 Alert, disoriented, but can follow simple instructions
 Alert, disoriented, and cannot follow simple instructions
 Not Alert

V. TREATMENT DEVICES

Heparin Lock - Date changed: _____
 IV / PICC / Portacath Access - Date inserted: _____
 Type: _____
 Internal Cardiac Defibrillator Pacemaker
 Wound Vac
 Other: _____
 Respiratory - Delivery Device: CPAP BiPAP
 Nebulizer Other: _____ Nasal Cannula
 Mask: Type _____
 Oxygen - liters: _____ % PRN Continuous
 Trach Size: _____ Type: _____
 Ventilator Settings: _____
 Suction

W. PERSONAL ITEMS

Artificial Eye Prosthetic Walker
 Contacts Cane Other
 Eyeglasses Crutches
 Dentures Hearing Aids
 U L Partial L R

X. COMMENTS (Optional)

Signature: _____
 Printed Name: _____