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

*Patient Name: Michael Love *Last 4 SSN: *DOB:

*A. PATIENT INFORMATION

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

*B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Deaf ☐ Normal ☐ Impaired
☐ Blind ☐ 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

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MDRO 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: Phone:
Admit Date: Discharge Date:
Admit Time: AM ☐ PM ☐ Discharge Time: AM ☐ PM ☐

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

☐ Anticoagulants	Date:	Time:	AM ☐ PM ☐
☐ Antibiotics	Date:	Time:	AM ☐ PM ☐
☐ Insulin	Date:	Time:	AM ☐ PM ☐
☐ Other:	Date:	Time:	AM ☐ PM ☐

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: AM ☐ PM ☐

*N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders	☐ Treatment Orders
☐ Discharge Summary	☐ Includes Wound Care
☐ Medication Reconciliation	☐ Lab reports
☐ Discharge Medication List	☐ X-ray ☐ EKG
☐ PASRR Forms	☐ CT Scan ☐ MRI
☐ Social and Behavioral History	☐ History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)

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O. VITAL SIGNS

Date: Time Taken: AM ☐ PM ☐

HT: FEET INCHES WT:

Temp: BP: /

HR: RR: Sp02:

*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:

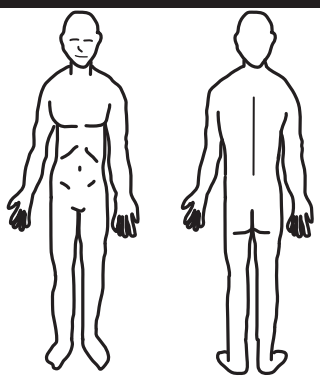
Left:

☐ Full ☐ Partial ☐ None

Right:

☐ Full ☐ Partial ☐ None

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: _____

*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.

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

*Effective date of medical condition: _____ *Physician/ARNP/PA License #: _____

*Physician/ARNP/PA Signature: _____ *Date: _____

*Printed Physician/ARNP/PA Name & Title: _____ *Phone Number: _____

Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____