myNEXUS

INPATIENT REHABILITATION FACILITY CONTINUED STAY REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

FOR FASTER AUTHORIZATION, PLEASE VISIT:
https://portal.mynexuscare.com

Date of Request:	☐ Standard ☐ Retro	☐ Urgent Request: *Note: Expedited organization determinations (urgent requests), can only be requested by the Member (or their representative) or a Physician. See CMS Chapter 13 regulation: 50.1*

Member Information:

Member Name:	Member ID:	Date of Birth:

Requesting IRF Facility Information		
Facility Name:		
NPI:	Attending Physician:	Is there a medical power of attorney? □ Yes □ No □ Unknown
Phone:	Attending Physician NPI:	
Fax:		Name and relationship to patient:
IRF Facility Contact Name:	IRF admission date:	
IRF Facility Contact Phone:	Anticipated IRF Discharge date:	*If available, please attach POA/AOR with request*
IRF Facility Contact Fax:	Is member currently in your facility? ☐ Y ☐ N	Does the patient have an advanced directive? □ Yes □ No □ Unknown

INSTRUCTIONS

Submission MUST include the following as part of your referral package:

□ All pages of this referral form (fully completed – include comments).
□ Rehabilitation H & P
□ Specialty consultations
□ Overall plan of care
□ Admission Orders
□ Current medication list/record
□ Interdisciplinary Team Assessment
□ 3 days of most recent physician notes.
□ 1-2 days of most recent nursing notes.
□ 1-2 days of most recent wound care notes, if applicable.
□ Therapist assessment/ current progress notes that provide relevant supplemental information.
(e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST.
□ Most recent diagnostics (CT scans / X-ray reports) and lab work.

MEDICAL AND PHYSICAL STATUS

Admitting ICD-10 Code(s)			
1 (Primary)	2	3	4

Clinical Category			
☐ Stroke	☐ Neurologic Disorder- NOS	☐ Fracture of Femur	☐ Major Multiple Trauma
☐ Spinal Cord Dysfunction	☐ Arthritis- Inflammatory or severe degenerative	☐ Burns	☐ Medically Intensive
☐ Brain Injury	☐ Knee or Hip Replacement	☐ Amputation	☐ Other
Reason For Continued Rehabilitation Stay: **Past Medical History/Other Medical Conditions:**			

Risk of Complications: □ Low □ Moderate □ High	
Expected Overall Level of Improvement: □Independent/Mod I □ Supervision □CGA □MINA□ MODA□ MAXA □DEP □Unknown	**Rehabilitation Potential:** □ Poor □ Fair □ Good □ Excellent

Select all the following skilled services the patient will require for post-acute care.	
☐ Medical and/or nursing care	Anticipated frequency: □ Daily □ Every other day □ Weekly □ Unknown
☐ Physical therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week
☐ Occupational therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week
☐ Speech therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____

Weight _____ **Height** _____

Alert and oriented _____ **Able to follow commands?** □ Yes □ No **Episodes of agitation?** □ Yes □ No **Increased confusion at night?** □ Yes □ No

Medical Needs – If any boxes are checked please provide details □ Open wounds □ Infections (list) □ IV therapy
□ Oxygen/Respiratory treatments □ Trach □ Vent □ Pain □ Dialysis □ 1:1 Supervision □ Ongoing outpatient medical treatments (i.e.: radiation/chemotherapy)
Details:

Nutrition Needs □ Dysphagic diet □ NPO □ PEG □ NG □ TPN
Details:

Current Level of Function:

Date of Current Therapy Status:		
Weight Bearing Status:		□ FWB □ WBAT □ PWB □ NWB □ Unknown
Ambulation:	# Feet:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Wheelchair Mobility (if applicable):		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Bed Mobility:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Transfers:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Stairs:	# Stairs:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Feeding:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Grooming/Hygiene:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Bathing:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Dressing:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Toileting:		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
DME Needed		□ Wheelchair □Walker □Cane □ Brace □Bedside Commode □Bath/Shower Chair □ Brace □ Other Additional Info:

Discharge Planning (general):	
Previous living situation □ Home alone □ Home with spouse □ Home with family/caregivers □Long Term Care □ Supportive housing □ Homeless □ Unknown □ Other (comment}: **Planned d/c living situation** □ Home alone □ Home with spouse □ Home with Family/Caregivers □Long Term Care □ Supportive housing □ Unknown □ Other (comment}:	
For discharge plans to return home:	**For discharge plans to long term care or supportive housing:**
Is there a caregiver identified and able to assist the patient? □Yes □No □Unknown **[IF YES]** □ 24hrs □ Daytime only □ Evening Only **[IF YES] Caregiver ability to provide care:** □ Grocery Shopping □ Meal Prep □ Non-Transfer Assistance (feeding/dressing) □ Transfer Assistance (in/out of bed, toileting) □ Full ADL Assistance **[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely?** □Yes □No □ Unknown **[IF YES] Has caregiver training been completed?** □Yes □No □ Unknown **Home Living Environment:** **# of steps to enter: _____Rails:** □Yes □No □ Unknown **Is there a ramp to enter?** □Yes □No □ Unknown **Bed 1st Floor** □Yes □No □ Unknown **Bath 1st Floor** □Yes □No □ Unknown **Is there ability for first floor setup?** □Yes □No □ Unknown **If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient?** □Yes □No □ Unknown **If yes, Name of Company:**	**Has a facility been chosen?** □ Yes □ No □ LTC resident □ Unknown **[IF YES] Name of facility:** **Has an application been completed?** □ Yes □ No □ LTC resident □ Unknown **Is it anticipated that a bed/room be available for the patient?** □ Yes □ No □ Unknown **Is it anticipated that the facility will be able to provide the level of care needed at discharge?** □ Yes □ No □ Unknown **Does patient require an application for Medicaid?** □ Yes □ No □ Unknown **Discharge Plan Comment:**

Comments or other pertinent information: