

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:	<input type="checkbox"/> Standard <input type="checkbox"/> Retro	<input type="checkbox"/> Urgent Request: <i>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</i>
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:
IRF Facility Contact Fax:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> N	If available, please attach POA/AOR with request Does the patient have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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			
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neurologic Disorder- NOS	<input type="checkbox"/> Fracture of Femur	<input type="checkbox"/> Major Multiple Trauma
<input type="checkbox"/> Spinal Cord Dysfunction	<input type="checkbox"/> Arthritis- Inflammatory or severe degenerative	<input type="checkbox"/> Burns	<input type="checkbox"/> Medically Intensive
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Knee or Hip Replacement	<input type="checkbox"/> Amputation	<input type="checkbox"/> Other
Reason For Continued Rehabilitation Stay:			
Past Medical History/Other Medical Conditions:			

Risk of Complications: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	
Expected Overall Level of Improvement: <input type="checkbox"/> Independent/Mod I <input type="checkbox"/> Supervision <input type="checkbox"/> CGA <input type="checkbox"/> MINA <input type="checkbox"/> MODA <input type="checkbox"/> MAXA <input type="checkbox"/> DEP <input type="checkbox"/> Unknown	Rehabilitation Potential: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent

Select all the following skilled services the patient will require for post-acute care.	
<input type="checkbox"/> Medical and/or nursing care	Anticipated frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Every other day <input type="checkbox"/> Weekly <input type="checkbox"/> Unknown
<input type="checkbox"/> Physical therapy to address functional impairment	Anticipated Frequency: ___ hours/day ___ # days/week
<input type="checkbox"/> Occupational therapy to address functional impairment	Anticipated Frequency: ___ hours/day ___ # days/week
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Episodes of agitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Increased confusion at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Needs – If any boxes are checked please provide details <input type="checkbox"/> Open wounds <input type="checkbox"/> Infections (list) <input type="checkbox"/> IV therapy <input type="checkbox"/> Oxygen/Respiratory treatments <input type="checkbox"/> Trach <input type="checkbox"/> Vent <input type="checkbox"/> Pain <input type="checkbox"/> Dialysis <input type="checkbox"/> 1:1 Supervision <input type="checkbox"/> Ongoing outpatient medical treatments (i.e.: radiation/chemotherapy) Details:
Nutrition Needs <input type="checkbox"/> Dysphagic diet <input type="checkbox"/> NPO <input type="checkbox"/> PEG <input type="checkbox"/> NG <input type="checkbox"/> TPN Details:

Current Level of Function:

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

Discharge Planning (general):	
Previous living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with spouse <input type="checkbox"/> Home with family/caregivers <input type="checkbox"/> Long Term Care <input type="checkbox"/> Supportive housing <input type="checkbox"/> Homeless <input type="checkbox"/> Unknown <input type="checkbox"/> Other (comment):	
Planned d/c living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with spouse <input type="checkbox"/> Home with Family/Caregivers <input type="checkbox"/> Long Term Care <input type="checkbox"/> Supportive housing <input type="checkbox"/> Unknown <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown [IF YES] <input type="checkbox"/> 24hrs <input type="checkbox"/> Daytime only <input type="checkbox"/> Evening Only [IF YES] Caregiver ability to provide care: <input type="checkbox"/> Grocery Shopping <input type="checkbox"/> Meal Prep <input type="checkbox"/> Non-Transfer Assistance (feeding/dressing) <input type="checkbox"/> Transfer Assistance (in/out of bed, toileting) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown [IF YES] Has caregiver training been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Home Living Environment: # of steps to enter: _____ Rails: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is there a ramp to enter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Bed 1st Floor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Bath 1st Floor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is there ability for first floor setup? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Name of Company:	Has a facility been chosen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> LTC resident <input type="checkbox"/> Unknown [IF YES] Name of facility: Has an application been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> LTC resident <input type="checkbox"/> Unknown Is it anticipated that a bed/room be available for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is it anticipated that the facility will be able to provide the level of care needed at discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Does patient require an application for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Discharge Plan Comment:

Comments or other pertinent information:

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