

SKILLED NURSING 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://www.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, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)</i>
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Member Information:		
Member Name:	Member ID:	Date of Birth:

Requesting 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:	
SNF Facility Contact Name:	SNF admission date:	If available, please attach POA/AOR with request
SNF Facility Contact Phone:	Anticipated SNF Discharge date:	
SNF Facility Contact Fax:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> N	Does the patient have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

- All pages of this referral form (fully completed – include comments).
- SNF H & P
- Specialty consultations
- Overall plan of care
- Admission Orders
- Current medication list/record
- Interdisciplinary Team Assessment (if completed)
- 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.

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

Clinical Category			
<input type="checkbox"/> Acute Neurologic	<input type="checkbox"/> Wound	<input type="checkbox"/> Major Joint Replacement or Spinal Surgery	<input type="checkbox"/> Other
<input type="checkbox"/> Acute Infections	<input type="checkbox"/> Medical Management	<input type="checkbox"/> Orthopedic Surgery (Except - Major Joint or Spinal Surgery)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Cancer	<input type="checkbox"/> Non-Surgical Orthopedic/Musculoskeletal	
<input type="checkbox"/> Pulmonary	<input type="checkbox"/> General weakness/deconditioning	<input type="checkbox"/> Non-Orthopedic Surgery	

Reason For Continued Skilled Stay:
Other Medical Conditions:

Prior Level of Function Immediately Before Hospital Stay: Only fill in if not previously completed.

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:		<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 <input type="checkbox"/> N/A
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
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
Previously used DME: <input type="checkbox"/> W/C <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"/> Unknown		
<input type="checkbox"/> Other (describe):		

Current Orders:

<input type="checkbox"/> Medical and/or nursing care	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	Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Occupational therapy to address functional impairment	Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Speech therapy to address functional impairment	Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown

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

Barriers to Discharge:	
If there are medical barriers to discharge, please document below:	
<input type="checkbox"/> Respiratory Care	<input type="checkbox"/> Naso-pharyngeal or deep tracheal suctioning <input type="checkbox"/> Ventilator management and/or weaning <input type="checkbox"/> Nebulizer treatments ≥ 2 times/day <input type="checkbox"/> Tracheotomy present
<input type="checkbox"/> IV/IM Medications	<input type="checkbox"/> IV medication ≥ 2 times/day that patient cannot self-administer. Patient does not have assistance at home and cannot practically travel to an infusion center. <input type="checkbox"/> IM medication ≥ 2 times/day and patient cannot self-administer. <input type="checkbox"/> Central line or multiple peripheral IV lines Type of line: _____ Insertion Date: _____ Medication: Name: _____ Dosage: _____ Frequency: _____ Estimated stop date: _____
<input type="checkbox"/> Nutritional Support	Diet Type <input type="checkbox"/> NPO <input type="checkbox"/> TF <input type="checkbox"/> TPN <input type="checkbox"/> Oral <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Pureed <input type="checkbox"/> Other: Route <input type="checkbox"/> NG <input type="checkbox"/> PEG <input type="checkbox"/> J Tube <input type="checkbox"/> Dobhoff Insertion date: _____ Formula: _____ Amount/Rate: _____ <input type="checkbox"/> Initiation of tube feedings ≥ 500 ml daily or ≥ 26% of daily caloric intake is required. <input type="checkbox"/> Initiation of intravenous (TPN) feeding requires skilled nursing care.
<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications requiring skilled nursing care.
<input type="checkbox"/> Urinary	<input type="checkbox"/> Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required. <input type="checkbox"/> Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home.

<input type="checkbox"/> Wound Care	<input type="checkbox"/> Multiple Stage II <input type="checkbox"/> Stage III or IV Decubitus Wound(s) <input type="checkbox"/> Other wound(s) that require(s) multiple dressing changes within a 24-hour period Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No Please answer for each wound: Location: Date of Measurement: Size: L x W x D (cm) = _____ x _____ x _____ Stage: Description: Treatment:	Location: Date of Measurement: Size: L x W x D (cm) = _____ x _____ x _____ Stage: Description: Treatment: Location: Date of Measurement: Size: L x W x D (cm) = _____ x _____ x _____ Stage: Description: Treatment:
Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> HD <input type="checkbox"/> Peritoneal Frequency: _____ Access: _____	
<input type="checkbox"/> Other	Describe: _____	
Comments:	Please use this space to provide additional detail on ongoing needs for skilled nursing care:	

If there are physical barriers to discharge, please document below:

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
Additional DME required for discharge: <input type="checkbox"/> W/C <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"/> Unknown		
<input type="checkbox"/> Other (describe): _____		

If there are Cognitive/Mood/Speech barriers to discharge, please document below:

Mental Status: Baseline _____ **Current:** Oriented X _____:

Level of consciousness: awake and alert lethargic confused delirious agitated obtunded

Other: dementia short term memory deficits long term memory deficits unable to follow 1-2 step commands depression anxiety

Speech: expressive aphasia receptive aphasia apraxia dysarthria

Comment: _____

Care Conference Date/Discussion:

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:**

<p>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</p> <p>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</p> <p>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:</p>	<p>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</p> <p>Discharge Plan Comment:</p>
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Additional Comment:

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