☐ CONTINUED STAY AUTHORIZATION / * DISCHARGE SUMMARY ☐

Member Name: ______________________________ HAP ID#:_________________ Today's Date:___________________

Currently Admitted to:________________________________ Admission Date: ______________________

This progress report for dates of care: _____/______/_____ through ______/_______/_____
(month/day/year) (month/day/year)

Person completing this form: ____________________ Telephone or Pager: ( )________________ Fax: ( )_________________

Care Conference Date: ______________________Family/relationship assisting with Plan of Care: ___________________________________

A. WEEKLY DISCHARGE PLANNING UPDATE: ANTICIPATED Discharge date: ____/____/___ * **ACTUAL Discharge Date :** ___/____/___

To: ☐ Own Residence ☐ Assisted Living ☐ Reside with: __________________________________ ____________________________

Homecare Ordered: Y or N

Barriers to Discharge____

Home Eval Date: _______________________Findings:____

Education completed by member/family:____

Comments:____

____

B. CLINICAL STATUS:

Cognitive Status: ☐ Alert & Oriented x 3 ☐ Alert & Oriented x 2 ☐ Alert & Oriented x 1 ☐ Not Alert & Oriented

☐ Able ☐ Unable to follow **1** **2** step directions (circle appropriate)

Behavioral Symptoms (new onset or increasing):____

____

____

NUTRITIONAL STATUS: ☐ Adequate ☐ Not Adequate (***Reason:***_______________________________________) Weight___________

Route: ☐PO ☐TPN ☐GI tube Formula & Rate____

Date of last change to formula or rate:____

Skin: ☐ Intact ☐ Not Intact (***If <u>not intact</u> COMPLETE wound assessment sheet***)

Pain Scale: (none) 0 - 1 - 2 - 3 - 4 – 5 - 6 – 7 – 8 – 9 – 10 Max (severe) **Location:**____

Pain Medication: (***Frequency & dose***)____

Pain Managed: YES NO

IV THERAPY:

Type of line & location:_____________________

IV Medication (s) (***including dosage and frequency***)____

____

Expected duration of treatment:________________________________(***Include end date of order***)_____________________________

Respiratory Interventions/O2:____O2 sat:________________________

Isolation for:____Anti Infectants:____

ANY ADDITIONAL COMMENTS / ISSUES / CONCERNS: ____

____

____

____

This section to be completed for continued authorization of therapy services. **Member Name:**

C. THERAPY / REHAB – FUNCTIONAL STATUS:

***Fields identified with an asterisk must be completed with submission of first review.**

KEY FOR PHYSICAL/OCCUPATIONAL THERAPY

7 = Independence	3 = Moderate Assist 25 – 49%
6 = Modified Independence	2 = Maximum Assist 50-74%
5 = Stand By Assist	1 = Dependent > 75%
4 = Minimal Assist < 25%	Balance: S= Static D= Dynamic -- Poor, Fair or Good

OCCUPATIONAL THERAPY – PROGRESS REPORT

	***Prior Level of Function**	***Evaluation** / /	***Week #1** / /	Week #2 / /	Week #3 / /	Week #4 / /	***Goal**	Status on D/C / /
Eating								
Grooming								
Bathing UE Bathing LE								
Dressing UE Dressing LE								
Toileting								
Bed Mobility								
Transfer – bed								
Transfer –toilet								
Sitting Balance Stand. Balance	S: D: S: D:	S: D: S: D:	S: D: S: D:	S: D: S: D:	S: D: S: D:	S: D: S: D:	S: D: S: D:	S: D: S: D:

ELOS for OT goal achievement: ________________________________Client/Family Instructions:____
Comment:____
____

PHYSICAL THERAPY – PROGRESS REPORT

	***Prior Level of Function**	*** Evaluation** / /	***Week #1** / /	Week #2 / /	Week #3 / /	Week #4 / /	***Goal**	Status on D/C / /
Bed Mobility								
Bed/Mat Transfers								
Gait								
Ambulation Distance (feet)								
Wheelchair Management								
Stairs								
Fall Recovery								
Residential Mobility								
Car Transfers								
Community Mobility								

ELOS for OT goal achievement: ________________________________Client/Family Instructions:____
Comment:____
____

SPEECH THERAPY - PROGRESS REPORT ***MEMBER NAME:***

***Fields identified with an asterisk must be completed with submission of first review.**

KEY FOR DYSPHAGIA TREATMENT

7 = **Independent** -Swallowing Within Functional Limits.
6 = **Mod. Independent** – Swallowing almost always functional with added time.
5 =**Supervision** – Swallowing almost always functional with added time and use of cues.
4 = **Min** – Swallowing effective 75-90% of the time.
3 = **Moderate** – Swallowing frequently effective 50-75%
2 = **Max** – Swallowing is severely impaired; functional 25-50%
1 =**Dependent** – Swallowing is totally dysfunctional. NPO.

Swallowing Liquids:	***Prior Level of Functioning**	*** Evaluation Date** / /	***Week #1 Date** / /	Week #2 Date / /	Week #3 Date / /	Week #4 Date / /	***Goal**	Status on D/C Date / /
Pudding Thick								
Honey Thick								
Nectar Thick								
Thin								
Swallowing Solids:	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Pureed								
Mechanical Soft								
Regular								
Swallows medications								

***Fields identified with an asterisk must be completed with submission of first review.**

KEY FOR APHASIA TREATMENT

6 = **Independent**
5 = **Adequate Function** (95%)
4 = **Mild Dysfunction** (75-95%)
3 = **Moderate Dysfunction** (50-75%)
2 = **Marked Dysfunction** (25-50%)
1 = **Severe Dysfunction** (0-25%)
DNT = **Did Not Test**

	***PriorLevel of Functioning**	***Evaluation Date** / /	***Week #1 Date** / /	Week #2 Date / /	Week #3 Date / /	Week #4 Date / /	***Goal**	Status on D/C Date / /
Receptive Language	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Auditory								
Reading								
Expressive Language	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Verbal								
Written Expression								
Non-Verbal Expression								

ELOS for OT goal achievement: ________________________________Client/Family Instructions:____
Comment:____
____