CarePartners of Connecticut

Skilled Nursing Facility Review Form

This form is to assist skilled nursing facilities with providing clinical updates for CarePartners of Connecticut members. Please complete the form and fax to the appropriate care manager. A complete listing of care managers is available on the CarePartners of Connecticut website.

Today's Date: _____

Member Name: _____ Member ID#: _____ Date of Birth: _____

Facility: _____ Facility Care Manager:_____

Phone #: _____ Fax #: _____

Estimated length of stay: _____**** PLEASE ATTACH MAR WITH FIRST REVIEW****

KEY

IND	SUPV
CG	MIN A
MOD A	MAX A
DEP	

	Review #1 Date: _____	**Review #2** Date: _____	**Review #3** Date: _____	**Review #4** Date: _____
Gait				
Weight bearing				
Distance / AD				
Level of assist				
Stairs # / Rails				
Bed mobility				
Standing balance				
Transfers				
Activity TOL				
Bathing UB				
Bathing LB				
Dressing UB				
Dressing LB				
Toilet trans				
Toilet hygiene				
Cognition/Swallow				
HT / WT				
Resp / 02 / 02 sat				
Bowel / bladder				
Skin integrity				
Pain mgmt.: 0-10				
Medication Monitor / Change				

ADDITIONAL COMMENTS:

**** PLEASE USE A SEPARATE FORM FOR DISCHARGE PLANNING INFORMATION****