Comagine Health

Physical Rehabilitation Review Worksheet

Providers with no access to the Comagine Health Provider Portal may use this form.

Call Date: _____ Caller: _____ Reference # _____

Admit Date: _____

Patient's Name: _____

Medicaid #: _____

Rehabilitation Facility: _____

Phone #: _____

New Procedures: _____ Date: _____

In general, has measurable improvement been documented weekly? Yes ☐ No ☐

Indicate:

1. Specific improvement—or lack of improvement—in the following areas, and

_____

_____

2. Revision of goals, if necessary

_____

_____

Improvements		**Comments**
Cognitive function	Y ☐ N ☐	_____
Communication	Y ☐ N ☐	_____
Continence, bowels	Y ☐ N ☐	_____
Continence, bladder	Y ☐ N ☐	_____
Mobility	Y ☐ N ☐	_____
Pain management	Y ☐ N ☐	_____
Perceptual motor function	Y ☐ N ☐	_____
Self-care activities	Y ☐ N ☐	_____

Comagine Health

Patient Name:_____

Intensity of Service

Will the progressive therapy program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

_____ADLs

_____Bed mobility/transfers

_____Home lifestyle modifications

_____Positioning/splinting

_____Pulmonary rehabilitation

_____ROM/strengthening

_____Speech language retraining

_____Swallowing retraining

_____Wheelchair mobility/ambulation/balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehab evaluations completed within 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this patient? _____

_____

Program Coordination

What is the ongoing needs assessment/procurement? _____

_____

What instruction does the patient require? _____

_____

What is identified as discharge needs, barriers, patient support systems, and patient capabilities? _____

_____

Comagine Health

Patient Name: _____

Disposition Planned

1. If goals achieved:_____
2. If goals not achieved:_____

Physiatrist's Plan of Care and Recommendation (if applicable)

_____

_____

_____

_____

_____

_____

_____

Number of days requested_____

Number of days approved_____

Approved until_____

Authorization #_____

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Thank you.

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