LTAC/REHAB/SNF: INFO NEEDED FOR PRE-ADMISSION OR ADMISSION REVIEW

1. Reason for admission
2. Acute hospital level of care comorbid condition #1
3. Acute hospital level of care comorbid condition #2
4. Acute hospital level of care comorbid condition #3
5. New functional limitation (if any)
6. History & Physical (medical admissions record)
7. Progress notes (To/From dates required)
8. Discharge summary from hospital (if available)
9. Social Services assessment
10. Discharge planning
11. Schedule of outside appointments
12. PT/OT/ST evaluations with recommendations & goals
13. Respiratory therapy orders & interventions
14. Respiratory status (chest PT, O2, hi flow, NIPPV, etc.)
15. Ventilator settings (if any)
16. Neuro status (Glasgow scale, seizures, etc.)
17. Mental status (sitter, chemical/physical restraints, etc.)
18. Lab values
19. Diagnostics (imaging, etc.)
20. Vital Signs (current day of admit or w/in previous 24 hours)
21. Nutrition – related labs, weight loss, other factors (fistula, etc.)
22. Wounds (if any)
    - measurements
    - wound care orders
    - adjunctive wound therapies
24. Infection (if any)
    - type of infection
    - treatment
    - date tx started
    - est tx end date