



MEDICAL CERTIFICATION FOR NURSING FACILITY/SERVICE AND HOME- AND COMMUNITY-BASED SERVICES FORM (Replaces Patient Transfer and Continuity of Care Form)

(A) FACILITY INFORMATION

Facility From \_\_\_\_\_ Admission Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility To \_\_\_\_\_

(B) DEMOGRAPHIC INFORMATION

Individual's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Individual's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Individual's Address \_\_\_\_\_ Phone Number \_\_\_\_\_ Nearest Relative/Health Care Surrogate \_\_\_\_\_ Phone Number \_\_\_\_\_

PHYSICIAN INFORMATION

Name \_\_\_\_\_ Will you care for individual in NF? \_\_\_\_\_ Yes \_\_\_\_\_ No If no, referred to \_\_\_\_\_ Principal Diagnosis \_\_\_\_\_ Secondary Diagnosis \_\_\_\_\_ Discharge Diagnosis \_\_\_\_\_ (Problem List may be attached) Surgery Performed & Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Allergy/Drug Sensitivity \_\_\_\_\_

MEDICATION AND TREATMENT ORDERS (copies may be attached)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(C) PREAMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION

(Complete for admission to NF only) 1. Is dementia the primary diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No 2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? \_\_\_\_\_ Yes \_\_\_\_\_ No 3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that apply) \_\_\_\_\_ Schizophrenia \_\_\_\_\_ Panic or severe anxiety disorder \_\_\_\_\_ Mood disorder \_\_\_\_\_ Personality disorder \_\_\_\_\_ Somatoform disorder \_\_\_\_\_ Other psychotic or mental disorder leading to chronic disability \_\_\_\_\_ Paranoia \_\_\_\_\_ 4. Has the individual received MI services within the past two years? \_\_\_\_\_ Yes \_\_\_\_\_ No 5. Is the individual a danger to self or others? (please attach explanation) \_\_\_\_\_ Yes \_\_\_\_\_ No 6. Is the individual on any medication for the treatment of a serious mental illness or psychiatric diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No 7. If yes, is the MI or psychiatric diagnosis controlled with medication? \_\_\_\_\_ Yes \_\_\_\_\_ No 8. Is the individual being admitted from a hospital after receiving acute inpatient care? \_\_\_\_\_ Yes \_\_\_\_\_ No 9. Does the individual require nursing facility services for the condition for which he/she received care in the hospital? \_\_\_\_\_ Yes \_\_\_\_\_ No 10. Has the physician certified the individual is likely to require less than 30 days of nursing facility services? \_\_\_\_\_ Yes \_\_\_\_\_ No

(D) ADDITIONAL ORDERS (Orders may be attached)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(J) TYPE OF CARE RECOMMENDED (MUST BE COMPLETED AND SIGNED)

Check one \_\_\_\_\_ Skilled Nursing Extended Care Facility (ECF), Duration \_\_\_\_\_ \_\_\_\_\_ Intermediate Care: Duration \_\_\_\_\_ \_\_\_\_\_ I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization. \_\_\_\_\_ I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement. \_\_\_\_\_

Print Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax \_\_\_\_\_ Email Contact Address \_\_\_\_\_

Physician's Signature and Date Required \_\_\_\_\_

(E) HISTORY & PHYSICAL AND LABS

1. PHYSICAL EXAM (History & Physical may be attached) Head Ears Eyes Nose & Throat (HEENT) \_\_\_\_\_ Neck \_\_\_\_\_ Cardiopulmonary \_\_\_\_\_ Abdomen \_\_\_\_\_ GU \_\_\_\_\_ Rectal \_\_\_\_\_ Extremities \_\_\_\_\_ Neurological \_\_\_\_\_ Other \_\_\_\_\_ Free from communicable diseases \_\_\_\_\_ Yes \_\_\_\_\_ No 2. LABORATORY FINDINGS (Reports may be attached) TB Test \_\_\_\_\_ Yes \_\_\_\_\_ No Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Yes \_\_\_\_\_ No Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_

(F) IMMUNIZATIONS GIVEN

\_\_\_\_\_ Pneumococcal Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ Influenza Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ Tetanus and Diphtheria Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ Herpes Zoster Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(G) PHYSICAL THERAPY (Attach Orders)

\_\_\_\_\_ New Referral \_\_\_\_\_ Continuation of Therapy

FREQUENCY OF THERAPY INSTRUCTIONS

\_\_\_\_\_ Stretching \_\_\_\_\_ Coordinating Activities \_\_\_\_\_ Progress bed to wheelchair \_\_\_\_\_ Passive Range of Motion (ROM) \_\_\_\_\_ Non-weight bearing \_\_\_\_\_ Recovery to full function \_\_\_\_\_ Partial weight bearing \_\_\_\_\_ Wheelchair independent \_\_\_\_\_ Active assistive \_\_\_\_\_ Full weight bearing \_\_\_\_\_ Complete ambulation \_\_\_\_\_ Active \_\_\_\_\_ Progressive resistive \_\_\_\_\_ Sensation Impaired: \_\_\_\_\_ Yes \_\_\_\_\_ No PRECAUTIONS Restrict Activity: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Cardiac \_\_\_\_\_ Other \_\_\_\_\_

ADDITIONAL THERAPIES (Attach Orders)

\_\_\_\_\_ Occupational Therapy \_\_\_\_\_ Respiratory Therapy \_\_\_\_\_ Speech Therapy \_\_\_\_\_ Other \_\_\_\_\_

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

\_\_\_\_\_ Catheter Care \_\_\_\_\_ Diabetic Care \_\_\_\_\_ Changing Feeding Tube \_\_\_\_\_ Monitor Blood Sugar/Frequency \_\_\_\_\_ Dressing Changes \_\_\_\_\_ Administer Insulin \_\_\_\_\_ Ostomy Care \_\_\_\_\_ Tube Feeding \_\_\_\_\_ Wound Care \_\_\_\_\_ Oxygen (Select from below) \_\_\_\_\_ Suctioning \_\_\_\_\_ PRN \_\_\_\_\_ Trach Care \_\_\_\_\_ Continuous @L/min \_\_\_\_\_ Instructions \_\_\_\_\_

(I) SPECIAL DIET ORDERS (Orders may be attached)

\_\_\_\_\_  
\_\_\_\_\_

Rehab Potential (check one) \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Admission Date to Nursing Facility \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date of Medical Condition \_\_\_\_/\_\_\_\_/\_\_\_\_

FOR ONLINE APPLICANT USE ONLY IF APPLYING FOR MEDICAID, PLEASE INCLUDE DCF ACCESS CONFIRMATION NUMBER BELOW:

**ADLs ARE AT TIME  
OF NF ADMISSION**

INDIVIDUAL'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

<b>(K) VISION</b> (w/glasses if used)	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Fair	<input type="checkbox"/> 3. Poor <input type="checkbox"/> 4. Blind	<b>AMBULATION</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. With assistive device <input type="checkbox"/> 3. With supervision	<input type="checkbox"/> 4. Requires assistance* <input type="checkbox"/> 5. Total help <input type="checkbox"/> 6. Bed bound
<b>HEARING</b> (w/aid if used)	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Fair	<input type="checkbox"/> 3. Poor <input type="checkbox"/> 4. Deaf	<b>ENDURANCE</b>	<input type="checkbox"/> 1. Tolerates distance (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermittent rest <input type="checkbox"/> 4. No tolerance <input type="checkbox"/> 3. Rarely tolerates short activities	
<b>SPEECH</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Fair <input type="checkbox"/> 3. Poor	<input type="checkbox"/> 4. Gestures or signs <input type="checkbox"/> 5. Unable to speak	<b>TRANSFER</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. With assistive device <input type="checkbox"/> 3. With supervision	<input type="checkbox"/> 4. Requires assistance* <input type="checkbox"/> 5. Bed bound
<b>COMMUNI- CATION</b>	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable		<b>WHEELCHAIR USE</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance with difficult maneuvering	<input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable <input type="checkbox"/> N/A
<b>MENTAL AND BEHAVIOR STATUS</b>	<input type="checkbox"/> 1. Alert <input type="checkbox"/> 2. Confused <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Comatose	<input type="checkbox"/> 5. Aggressive <input type="checkbox"/> 6. Disruptive <input type="checkbox"/> 7. Apathetic <input type="checkbox"/> 8. Wanders	<b>TOILETING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. With assistive devices <input type="checkbox"/> 3. With supervision <input type="checkbox"/> 4. Requires assistance <input type="checkbox"/> 5. Total assistance	<input type="checkbox"/> A- Bathroom <input type="checkbox"/> B - Bedside commode <input type="checkbox"/> C- Bedpan
<b>SKIN CONDITION</b>	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fatigue <input type="checkbox"/> 3. Irritations (rash) <input type="checkbox"/> 4. Open Wound	<input type="checkbox"/> 5. Decubitus Site: _____ Stage: _____ Size: _____	<b>BLADDER CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Occasional incontinence - once/week or less <input type="checkbox"/> 3. Frequent incontinence - up to once a day <input type="checkbox"/> 4. Total incontinence <input type="checkbox"/> 5. Catheter - indwelling	
<b>DRESSING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision <input type="checkbox"/> 3. Requires assistance* <input type="checkbox"/> 4. Has to be dressed		<b>BOWEL CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Occasional incontinence-once/week or less <input type="checkbox"/> 3. Frequent incontinence - up to once a day <input type="checkbox"/> 4. Total incontinence <input type="checkbox"/> 5. Ostomy	
<b>BATHING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision <input type="checkbox"/> 3. Requires assistance* <input type="checkbox"/> 4. Is bathed	<input type="checkbox"/> A- Tub <input type="checkbox"/> B - Shower <input type="checkbox"/> C- Sponge Bath	<b>FEEDING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Tray set up only <input type="checkbox"/> 3. Requires assistance <input type="checkbox"/> 4. Is fed	<input type="checkbox"/> 5. Aspirates
<b>TEACHING NEEDS</b>	<input type="checkbox"/> 1. Diabetic <input type="checkbox"/> 2. Cardiac	<input type="checkbox"/> 3. Ostomy <input type="checkbox"/> 4. Other (specify): _____	<b>DIET</b>	<input type="checkbox"/> 1. Full <input type="checkbox"/> 2. Mechanical Soft	<input type="checkbox"/> 3. Pureed <input type="checkbox"/> 4. Other (specify): _____

\*(HANDS ON NEEDED)  
Comments: \_\_\_\_\_

SIGNATURE AND TITLE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**(L) SOCIAL WORK ASSESSMENT**

Prior Living Arrangement \_\_\_\_\_

Long Range Plan/Agency Referrals \_\_\_\_\_

Adjustments to Illness or Disability \_\_\_\_\_

Comments \_\_\_\_\_