

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: _____

DOB: _____

A. PATIENT INFORMATION

Gender: ☐ Male ☐ Female
 Hispanic Ethnicity: ☐ Yes ☐ No
 Race: ☐ White ☐ Black ☐ Other: _____
 Language: ☐ English ☐ Other: _____

B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Normal ☐ Impaired
☐ Blind ☐ Deaf ☐ Hearing Aid L R

C. DECISION MAKING CAPACITY (PATIENT):

Capable to make healthcare decisions Requires a surrogate

D. EMERGENCY CONTACT

Name: _____ Name: _____
 Phone: _____ Phone: _____

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge: _____
 Reason for transfer (Brief Summary): _____

 Surgical procedures performed during stay: ☐ None

 Other diagnoses: _____

F. INFECTION CONTROL ISSUES

PPD Status: Positive Negative Not known
 Screening date: _____
 Associated Infections/resistant organisms: _____
☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MIDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____
 Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

G. PATIENT RISK ALERTS

☐ None Known ☐ Harm to self ☐ Difficulty swallowing
☐ Elopement ☐ Harm to others ☐ Seizures
☐ Pressure Ulcers ☐ Falls ☐ Other: _____

RESTRAINTS: Yes No

Types: _____

Reasons for use: _____

ALLERGIES: None Known Yes, List below:

Latex Allergy: Yes No Dye Allergy/Reaction: Yes No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	Yes	No
Living Will	Yes	No
DO NOT Resuscitate (DNR)	Yes	No
DO NOT Intubate	Yes	No
DO NOT Hospitalize	Yes	No
No Artificial Feeding	Yes	No
Hospice	Yes	No

I. TRANSFERRED FROM

Facility Name: _____
 Date: _____ Unit: _____
 Phone: _____ Fax: _____
 Discharge Nurse: _____
 Admit Date: _____ Discharge Date: _____
 Admit Time: _____ Discharge Time: _____

J. TRANSFERRED TO

Facility Name: _____
 Address 1: _____
 Address 2: _____
 Phone: _____ Fax: _____

K. PHYSICIAN CONTACTS

Primary Care Name: _____
 Phone: _____
 Hospitalist Name: _____
 Phone: _____

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
 Script sent for controlled substances (attached): Yes No
☐ Anticoagulants Date: _____ Time: _____
☐ Antibiotics Date: _____ Time: _____
☐ Insulin Date: _____ Time: _____
☐ Other: Date: _____ Time: _____

Has CHF diagnosis: Yes No

If yes; new/worsened CHF present on admission?

Yes No

Last echocardiogram: Date: _____ LVEF %

On a proton pump inhibitor? Yes No

If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? Yes No

If yes, specify reason(s): _____

Any critical lab or diagnostic test pending at the time of discharge? Yes No

If yes, please list: _____

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10): _____

Last administered: Date: _____ Time: _____

N. FOLLOWING REPORTS ATTACHED

<input type="checkbox"/> Physicians Orders	<input type="checkbox"/> Treatment Orders
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Includes Wound Care
<input type="checkbox"/> Medication Reconciliation	<input type="checkbox"/> Lab reports
<input type="checkbox"/> Discharge Medication List	<input type="checkbox"/> X-ray <input type="checkbox"/> EKG
<input type="checkbox"/> PASRR Forms	<input type="checkbox"/> CT Scan <input type="checkbox"/> MRI
<input type="checkbox"/> Social and Behavioral History	

ALL MEDICATIONS: (MAY ATTACH LIST)

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O. VITAL SIGNS

Date: _____		Time Taken: _____	
HT: _____		WT: _____	
Temp: _____		BP: _____	
HR: _____	RR: _____	SpO2: _____	

P. PATIENT HEALTH STATUS

Bladder: ☐ Continent ☐ Incontinent
☐ Ostomy ☐ Catheter Type: _____ date inserted: _____
 Foley Catheter: Yes No If yes, date inserted: _____
Indications for use:
☐ Urinary retention due to: _____
☐ Monitoring intake and output
☐ Skin Condition: _____
☐ Other: _____
Attempt to remove catheter made in hospital? Yes No
 Date Removed: _____
Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy
 Date of Last BM: _____
Immunization status:
 Influenza: Yes No Date: _____
 Pneumococcal: Yes No Date: _____

Q. NUTRITION / HYDRATION

Dietary Instructions: _____
 Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG
 Insertion Date: _____
 Supplements (type): ☐ TPN ☐ Other Supplements: _____
 Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - Frequency: _____
☐ OT - Frequency: _____
☐ Speech - Frequency: _____
☐ Dialysis - Frequency: _____

S. PHYSICAL FUNCTION

Ambulation: Not ambulatory Ambulates independently Ambulates with assistance Ambulates with assistive device	Transfer: Self Assistance 1 Assistant 2 Assistants
Devices: Wheelchair (type): Appliances: Prosthesis: Lifting Device:	Weight-bearing: Left: Full Partial None Right: Full Partial None

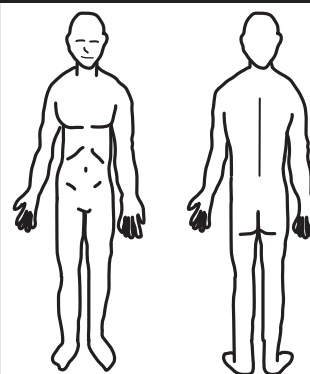
Y. PHYSICIAN CERTIFICATION

I certify the individual requires nursing facility (NF) services.
 The individual received care for this condition during hospitalization.
 I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Effective date of medical condition _____	Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physician/ARNP Signature: _____	Date: _____
Printed Physician/ARNP Name & Title: _____	Phone Number: _____
Person completing form: _____	Phone Number: _____ Date: _____

T. SKIN CARE – STAGE & ASSESSMENT

Pressure Ulcers
 (Indicate stage and location(s) of lesions using corresponding number:
 1.
 2.
 3.



List any other lesions or wounds: _____

U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, and cannot follow simple instructions
☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed: _____
☐ IV / PICC / Portacath Access - Date inserted: _____
 Type: _____
☐ Internal Cardiac Defibrillator ☐ Pacemaker
☐ Wound Vac
☐ Other: _____
 Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP
☐ Nebulizer ☐ Other: _____ ☐ Nasal Cannula
☐ Mask: Type _____
☐ Oxygen - liters: _____ % ☐ PRN ☐ Continuous
☐ Trach Size: _____ Type: _____
 Ventilator Settings: _____
☐ Suction

W. PERSONAL ITEMS

<input type="checkbox"/> Artificial Eye	<input type="checkbox"/> Prosthetic	<input type="checkbox"/> Walker
<input type="checkbox"/> Contacts	<input type="checkbox"/> Cane	<input type="checkbox"/> Other
<input type="checkbox"/> Eyeglasses	<input type="checkbox"/> Crutches	
<input type="checkbox"/> Dentures	<input type="checkbox"/> Hearing Aids	
<input type="checkbox"/> U <input type="checkbox"/> L <input type="checkbox"/> Partial	<input type="checkbox"/> L <input type="checkbox"/> R	

X. COMMENTS (Optional)

Signature: _____
 Printed Name: _____