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

*Patient Name: *Last 4 SSN: *DOB:

*A. PATIENT INFORMATION

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

*B. SIGHT / HEARING

SIGHT: ☐ Normal ☐ Impaired ☐ Blind
HEARING: ☐ Deaf ☐ Normal ☐ Impaired
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

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

F. INFECTION CONTROL ISSUES

PPD Status: Positive Negative Not known
Screening date: ______________________
Associated Infections/resistant organisms:

☐ MRSA Site: ______________________
☐ VRE Site: ______________________
☐ ESBL Site: ______________________
☐ MDRO 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: Phone:
Admit Date: Discharge Date:
Admit Time: AM PM Discharge Time: AM PM

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: AM PM
☐ Antibiotics	Date:	Time: AM PM
☐ Insulin	Date:	Time: AM PM
☐ Other:	Date:	Time: AM PM

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: AM PM

*N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ Medication Reconciliation ☐ Lab reports
☐ Discharge Medication List ☐ X-ray ☐ EKG
☐ PASRR Forms ☐ CT Scan ☐ MRI
☐ Social and Behavioral History History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)

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

*Patient Name: *Last 4 SSN: *DOB:

O. VITAL SIGNS

Date: Time Taken: AM PM

HT: FEET INCHES WT:

Temp: BP: /

HR: RR: Sp02:

*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:*

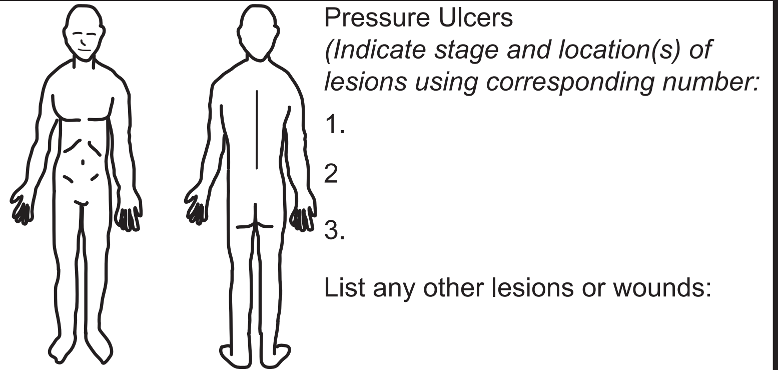
☐ Dialysis - *Frequency:*

*S. PHYSICAL FUNCTION

***Ambulation:**	***Transfer:**
Not ambulatory	Self
Ambulates independently	Assistance
Ambulates with assistance	1 Assistant
Ambulates with assistive device	2 Assistants

Devices:	**Weight-bearing:**
Wheelchair (type):	Left:
Appliances:	Full Partial None
Prosthesis:	Right:
Lifting Device:	Full Partial None

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

☐ Artificial Eye	☐ Prosthetic	☐ Walker
☐ Contacts	☐ Cane	☐ Other
☐ Eyeglasses	☐ Crutches	
☐ Dentures	☐ Hearing Aids	
☐ U ☐ L ☐ Partial	☐ L ☐ R	

X. COMMENTS (Optional)

Signature:____________________________

Printed Name:____________________________

*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.

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

*Effective date of medical condition: ______________________ *Physician/ARNP/PA License #: ______________________

*Physician/ARNP/PA Signature: ____________________________ *Date: ____________

*Printed Physician/ARNP/PA Name & Title:____________________________ *Phone Number: ____________

Z. PERSON COMPLETING FORM

Name: ____________________________ Phone Number: ______________ Date: ______________