INPATIENT REHABILITATION

CONTINUED STAY

REQUIRED SERVICE AUTHORIZATION INFORMATION

1. Does the patient continue therapy with at least 2 disciplines, PT, OT, SLP, 3 hours daily, 5 days per week: yes / no

a. List therapies the patient is currently receiving:

2. Please provide documentation of progress toward goals and continued improvement in function/reduction in limitations since the last review (Provide FIM scores if available):

3. Please provide the current care coordination and discharge plan (explain discharge planning-estimated length of stay, where the patient will be discharged to, community resources needed, etc.):

4. Please provide the needs assessment and procurement for discharge (This may include -hospital bed, hydraulic lifts, home modification, wheelchair, etc.):

5. Please provide the current medical and psychological management needs (example-medications, coping skills, pain, etc.):

6. Please provide the current patient/family teaching topics :

7. Please describe any other pertinent information related to this continued stay service authorization request:

8. Please provide any new onset of a medical instability(ies) interfering with therapy participation for more than three days:

9. Please indicate if the patient has reached a functional plateau or if the patient shows no significant functional improvement in a reasonable amount of time:

10. Is/Was there a pre-determined and reasonable time frame documented for goal achievement. Yes/no