univera HEALTHCARE

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Skilled Nursing Facility Recertification Form

Please complete and fax entire form. Incomplete information may delay review.

Function/Current	Eval Date: / /	Eval Date: / /	Eval Date: / /
Cognition	A & O x 1 2 3 4	A & O x 1 2 3 4	A & O x 1 2 3 4
Transfer	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2
Ambulation	Ind Sup CG Min Mod Max Total Assist 1 2 N/A Distance: Device: SW RW SC QC Other	Ind Sup CG Min Mod Max Total Assist 1 2 N/A Distance: Device: SW RW SC QC Other	Ind Sup CG Min Mod Max Total Assist 1 2 N/A Distance: Device: SW RW SC QC Other
Bed Mobility	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2
Stairs	N/A Ind Sup CG Min Mod Max Total Assist x 1 2 Steps:	N/A Ind Sup CG Min Mod Max Total Assist x 1 2 Steps:	N/A Ind Sup CG Min Mod Max Total Assist x 1 2 Steps:
ADL upper body Bathing/Dressing	Ind Sup CG Min Mod Max Total	Ind Sup CG Min Mod Max Total	Ind Sup CG Min Mod Max Total
ADL lower body Bathing/Dressing	Ind Sup CG Min Mod Max Total	Ind Sup CG Min Mod Max Total	Ind Sup CG Min Mod Max Total
Toileting	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2	Ind Sup CG Min Mod Max Total Assist 1 2
Speech			
Total Therapy Minutes (PT/OT/SLP)	____ Minutes/Week ____ Days/Week	____ Minutes/Week ____ Days/Week	____ Minutes/Week ____ Days/Week
Skilled Nursing			
IV Medication/Injections			
IV Infusion			
Wound: (measurements, treatments)			
Other			
Enteral/Parenteral Nutrition	Total Daily Calories/Rate	Total Daily Calories/Rate	Total Daily Calories/Rate
Anticipated Discharge Date	_____/_____/_____	_____/_____/_____	_____/_____/_____
Discharge to: (Circle)	Home, ALF, Custodial	Home, ALF, Custodial	Home, ALF, Custodial
Barriers (Actual or Potential)			
Therapist/RN Signature			

Attestation: Health Plan reserves the right to request supporting medical documentation for approval determinations.