

Skilled Nursing Facility and Inpatient Rehabilitation Assessment Form

Please Expedite*

Justification for Expedited Request:

If no justification given, request will be processed as standard

Submit requests to:

Online: www.WyoBlueAdvantage.com

Fax: 1-855-933-2664

Phone: 1-844-602-2570

*Please ONLY check this option if the provider believes waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

1. Member Information & Background

Patient Name: _____	Previous auth # (if applicable): _____
Member/Patient ID Number: _____	Requesting Provider: _____
Patient DOB: _____ Pt. phone: _____	Requesting Provider NPI#: _____
Patient Address: _____	Treating Provider: _____
_____	Treating Provider NPI#: _____
ICD-10 Code(s): _____	Admitting Provider: _____
CPT Code(s): _____	Admitting Provider NPI#: _____
Date of Admission: _____ TBD	Servicing Facility: _____
Type: Inpatient Rehab SNF	Svc Facility NPI#: _____
# Visits/Units/Days: _____	Facility Reviewer Name: _____
Authorization Date Span: _____ - _____	Phone #: _____ Fax #: _____

Admitting diagnosis with summary of acute hospital admission:

Past Medical History:

Surgical/Procedures and Dates:

This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.

This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Member Name: _____

Member ID: _____

Today's Date: _____

Initial Assessment

Reassessment Last approved date: _____

Chart notes are required to be submitted with this request, including:

- Hospital admission H&P
- Therapy notes (PT/OT/ST/wound)
- Care coordination notes to include social worker notes.

For SNF members, fax a signed/dated NOMNC form prior to member discharge.

2. Clinical Information

Height: _____ Weight: _____

BP: _____ HR: _____

Respiratory Rate: _____ Temperature: _____

Pulse ox: _____% NC / Liters: _____

A & O x: x1 x2 x3 x4

Tracheostomy CPAP BiPAP

Type: _____ Size: _____

Suction Freq: _____

Color & Amount: _____

Respiratory Tx: Yes No _____

Diet: NPO Oral TF TPN

Rate/Frequency/Type: _____

Bladder: Incontinent Catheter _____

Bowel: Incontinent Ostomy _____

Dialysis: Yes Acute Chronic
Hemodialysis Peritoneal Dialysis

Dialysis Access: _____ Freq/Days: _____

Pain Location: _____

Pain Treatment: _____

3. Medications

IV medications, with ending dates:

Vascular Access/Central lines:

Significant medications that affect functioning:

Member Name: _____

Member ID: _____

4. Skin

Skin Intact? Yes No

Wound /Incision #2: Stage: _____

Wound/Incision #1: Stage: _____

Location: _____

Location: _____

Wound Vac: Yes No

Wound Vac: Yes No

Size (L x W x D in cm)/Description: _____

Size (L x W x D in cm)/Description: _____

Treatment/Frequency: _____

Treatment/Frequency: _____

For additional wounds use section 11

5. Prior Level of Function

Prior level of function ADLs: _____

Resides: Alone W/ Spouse W/ Other _____

Support: Spouse Children Others _____

Home Description (steps to enter, levels, bed / bath location, etc.):

6. Key for Mobility and Self-Care Functioning

I	Independent
MI	Modified Independent
Sup	Supervision
SBA	Standby Assist
CGA	Contact Guard Assist

Min	Minimal
Mod	Moderate
Max	Maximum
Total	Total Assist

Member Name: _____

Member ID: _____

7. Physical Therapy

Bed Mobility: _____

Transfers: _____

Ambulation: _____

Distance: _____

Assistive Devices: _____

Stairs: _____

8. Occupational Therapy

Feeding: _____

Bathing (Upper Body): _____

Dressing (Upper Body): _____

Bathing (Lower Body): _____

Dressing (Lower Body): _____

Grooming: _____

Toileting / Hygiene: _____

ADL/Toilet Transfers: _____

9. Speech Therapy

Dysphagia Evaluation

Modified Barium Swallow

Aspiration Risk

Results/Risks /Recommendations:

Member Name: _____

Member ID: _____

10. Discharge plans

D/C Date: _____ Tentative Actual Discharge To _____

D/C Follow-up Appt Date: _____ Provider Name/Specialty: _____

D/C with: HHC Provider _____ HHC Phone: _____ Fax _____

Outpatient Provider _____ OP Prov. Ph#: _____ Fax: _____

DME _____ DME Phone: _____ Fax: _____

Contact Person at D/C: _____ Contact Phone # at D/C: _____

Barriers to Discharge:

11. Additional Comments