SNF/LTC INITIAL ASSESSMENT

SAN FRANCISCO HEALTH PLAN™

Please fax completed form to your facility's assigned SFHP Nurse.
All questions contained in this questionnaire are strictly confidential and will become part of the Residents' medical record.

Name (Last, First, M.I.): **DOB:** **Auth#:** **Admission Date:**

Facility: **Attending:**

Admit Dx: **Height:** **Weight:**

Co-Morbidities:

Admit Level of Care: ☐ Sub acute ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Custodial

Justification for Level:

D/C Plan: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS #hrs/month:

Current Barriers to D/C Plan:

Treatment Goals:

Prior Living Conditions:

Prior Level of Function:

Does Resident have social or family support? ☐ Yes ☐ No **Describe:**

Does Resident own DME? ☐ Yes ☐ No **Type?**

Does Resident have income? ☐ Yes ☐ No **How much per month?**

Does Resident Have an Advance Directive or Living Will? ☐ Yes ☐ No **DPOA:** **Phone Number:**

Does SNF/LTC Facility Provide Transportation? ☐ Yes ☐ No ☐ Other:

Indicate Transportation Needs: ☐ O_2 ☐ Cane ☐ Gurney ☐ Wheelchair ☐ Other

Does Resident have the potential to go back home when ready for discharge? ☐ Yes ☐ No **If No, Why?**

PATIENT SUPPORT/CAREGIVER

Name (Last, First, M.I.): **Relationship:**

Address: **Email:**

Party to Sign Contract:

Home Number: **Cell Number:** **Work Number:**

PERSONAL SAFETY & ACTIVITY LEVEL **Resident Care Needs** (Check all conditions that apply)

Dietary Requirements/Restrictions:

☐ Chemo	☐ Eloper/Wanderer	☐ Ileostomy	☐ O_2	☐ Trach	Wounds	☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/Frequency:		☐ Venous	Stage(s):
☐ Dialysis/Days	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Personal Safety

Does Resident have stairs at home?	☐ Yes ☐ No	☐ How many:			
Does Resident experience frequent falls?	☐ Yes ☐ No				
Does Resident have vision or hearing loss?	☐ Yes ☐ No	☐ Glasses	☐ Hearing Aids		
Indicate all appropriate assistive device(s) Resident uses:	☐ Wheelchair	☐ Cane	☐ Walker	☐ Other:	
• Ambulation x ft.	☐ Independent	☐ Max Assist	☐ Mod	☐ Min	
• Safety/Balance	☐ Good	☐ Fair	☐ Poor		

Current Level of Functioning:

Discharge Plan:

ADMISSION PACKET CHECKLIST (PLEASE SEND WITH ALL NEW)

Facesheet	☐ Yes ☐ No	**MDS** (Custodial)	☐ Yes ☐ No	**SNF/LTC Initial**	☐ Yes ☐ No
Physician Orders	☐ Yes ☐ No	**H & P**	☐ Yes ☐ No	**Therapy Evaluation** (Skilled)	☐ Yes ☐ No
IFT (Inter-facility transfer form)	☐ Yes ☐ No	**Wound Notes (If applicable)**	☐ Yes ☐ No	**Assigned SNFIST**	☐ Yes ☐ No
MC171	☐ Yes ☐ No				

MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY

Name the Drug(s):	Strength:	Frequency Taken:

Date of Review | Nurse Reviewer Printed Name | Nurse Reviewer Signature | Contact Phone Number