



**Skilled Nursing Facility/Inpatient Rehabilitation Fax Form**  
**FAX # Commercial 866-230-3424 / BlueCare, TennCareSelect 423-535-7790**  
**TELEPHONE # 1-800-882-2096**

Initial Request \_\_\_\_\_ Concurrent Review \_\_\_\_\_

<b>Commercial</b> <input type="checkbox"/>	<b>BlueCare</b> <input type="checkbox"/>	<b>TennCareSelect</b> <input type="checkbox"/>
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**Member Information**

Member Name: _____	Date of Birth: _____
Member Identification Number: _____	Reference Number: _____
Member Current Telephone Number: _____	

**SNF / Rehab. Information**

Date of Admission to Facility: _____	
Facility Name: _____	Contact Name: _____
Address: _____ + _____	
Phone Number: _____	Fax Number: _____
Provider Number: _____	NPI Number _____ Tax ID Number: _____
Facility Member is Transferring from: _____	

**Admitting Provider Information**

Prescribing Provider's Name: _____	
Address: _____	
Phone Number: _____	Fax Number: _____
Provider Number _____	NPI Number _____ Tax ID Number: _____

**Clinical Information**

Diagnosis: _____ _____
Height: _____ Weight: _____
Current Lab (e.g., hemoglobin & hematocrit, INR, PTT) _____
Has a Doppler study of the lower extremities been performed? Yes [ ] No [ ]

**Patient Level of Orientation**

**Rancho Level**

<input type="checkbox"/> Alert and Oriented	<input type="checkbox"/> Willing and Able to Participate	<input type="checkbox"/> Can Follow Commands
Types of Discipline (Therapy):	<input type="checkbox"/> Speech	<input type="checkbox"/> Occupational <input type="checkbox"/> Physical
Number of Hours per Day: _____		

Type of Surgery: \_\_\_\_\_  
 Date of Surgery: \_\_\_\_\_  
 Pain Control (by discharge):  PO  IV Please specify: \_\_\_\_\_  
 \_\_\_\_\_  
 Comorbidity/Past Medical History: \_\_\_\_\_  
 Function Status Prior to Admission: \_\_\_\_\_  
 \_\_\_\_\_  
 Home Environment:  
 Single or Multi Level: \_\_\_\_\_ Number of steps to enter home: \_\_\_\_\_  
 Number of steps within home: \_\_\_\_\_ Availability of caregiver: \_\_\_\_\_

**Current Functional Status (DAY PRIOR TO DISCHARGE from Acute Care Facility): FIMS Score (1 – 7)**

	Minimum	Moderate	Maximum	CGA	SBA	Assistive Devices
EATING						
DRESSING						
BATHING						
BED/MOBILITY						
SUPINE-SIT						
SIT-STAND						
TRANSFERS						
AMBULATION **DISTANCE**						

**Wound Care description: (length, width, drainage), treatment, frequency:**

**Progress toward goals/Changes in Plan of Care:**

**Caregiver teaching/training:**

**If Skilled Nursing Facility request, what are other skilled needs? (e.g. , IV antibiotics, TPN, oxygen, CPM etc.) Please be specific regarding dosage amounts, frequencies and CPM settings:**

**Requested length of stay:** \_\_\_\_\_

**Behavioral Health services for BlueCare members are coordinated through VSHP. Behavioral Health services for TennCareSelect members are coordinated through Premier Behavioral Health Systems of Tennessee. Please attach any supporting documentation.**

**Discharge Goals:**  
 Destination/Functional (Home with or without assist, Facility, etc.) \_\_\_\_\_