Washington State Health Care Authority

Acute Physical Medicine and Rehab Admit / Extension Request

Attn: HCA Acute PM&R Clinical Program Manager
360-725-5144
Fax: 360-725-1966

Incomplete forms will not be accepted

REFERENCE / AUTH NUMBER
TODAY'S DATE

REHAB COORDINATOR NAME	TELEPHONE NUMBER	FAX NUMBER	CONFERENCE DAY
☐ New Admit ☐ Extension	ATTENDING PHYSIATRIST	REHAB FACILITY NAME AND PROVIDER NPI	
CLIENT NAME	ProviderOne ID	BIRTH DATE	SOCIAL SECURITY NUMBER
CLIENT ADDRESS	CITY	STATE	ZIP CODE
CLIENT IS CURRENTLY AT ☐ Home ☐ SNF ☐ Hospital	NAME OF FACILITY	DATE OF ADMIT TO ACUTE CARE:	
CLIENT'S LIVING SITUATION PRIOR TO HOSPITALIZATION			
Was client independent prior to acute admit? ☐ Yes ☐ No	If not, describe prior functional level:		
DATE OF PROPOSED ADMIT (retroactive dates approved only on a case by case basis)	Prior acute inpatient rehab for this condition? ☐ Yes ☐ No If yes, where? Date?	ESTIMATED LOS	

PM&R-related Diagnoses (This diagnosis must be supported by the submitted medical records.)	ICD Dx	Description
	ICD Dx	Description
	ICD Dx	Description
	ICD Dx	Description

PERTINENT PAST MEDICAL Hx

SUMMARY OF GLOBAL DEFICIT

CURRENT FUNCTIONAL STATUS As of: _____ (date)

	Yes	No	Indep	Sba	Cga	Mina	Moda 1-2	Maxa 1-2	Dep
Ambulation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wheelchair	☐	☐	☐	☐	☐	☐	☐	☐	☐

Amb distance & Assistive Devices

Braces used? ☐ ☐ Type

	Indep	Sba	CGA	Mina	Moda 1-2	Maxa 1-2	Dep
Transfers	☐	☐	☐	☐	☐	☐	☐
UE dsg	☐	☐	☐	☐	☐	☐	☐
LE dsg	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐
Groom/Bath	☐	☐	☐	☐	☐	☐	☐

Diet Type ☐ Peg tube ☐ Trach? ☐ Yes ☐ No

Notes:

Continence	☐ Continent both	☐ Incont bowel	☐ Incont bladder	☐ Incont both	☐ Foley
Intermittent Cath	☐ Indep	☐ Min a	☐ Mod a		
Orientation A&O X:	Explain:				
Cog deficits? ☐ Yes ☐ No					
Explain:					
Speech deficits? ☐ Yes ☐ No					
Describe:					
Does client have carry over? ☐ Yes ☐ No Follows commands/%? ☐ 1 Step _____ % ☐ 2 Step _____ % ☐ Multiple _____ %					

Able to Participate Min 3 hrs Daily 7 Days/Week in Acute PM&R Activities ☐ Yes ☐ No	QUANTITATIVE REHAB GOALS

DISCHARGE PLAN

☐ Home alone ☐ Home with family ☐ AFH ☐ SNF ☐ Other

Describe:

Who will be the caregiver at D/C and relationship to patient?	ESTIMATED DC DATE

Submit the H&P, discharge summary, physiatry consult and neurology consult, if available.

I attest that all the information provided is accurate and supported by the attached medical records:

Signature of person completing the form: _____

Printed name and title: _____

Date Completed: _____

FORMS WITHOUT A SIGNATURE WILL NOT BE ACCEPTED