

REQUEST FOR CHANGE IN LEVEL OF CARE

NAME _____ XIX # _____ FACILITY _____
DOA _____ CURRENT DIAGNOSIS (INCLUDE DATE DIAGNOSED) _____

THERAPY ORDERED (TYPE) _____ DATE _____

CONDITIONS CURRENTLY PRESENT

CONSCIOUSNESS ___ CONTRACTURES ___ SYNCOPE ___ DYSPNEA ___ SEIZURES ___ TREMORS ___
ENEMA ___ INCONTINENCE ___ FRAILITY ___ VISION ___ PARALYSIS ___ HEARING ___
COMMUNICATION ___ DECUBITUS (>2CM) ___ NUMBER ___ STAGE ___ TREATMENT _____

PHYSICAL IMPAIRMENT STATUS 1. IMPROVING ___ 2. STABLE ___ 3. PROGRESSIVE ___
REHABILITATION POTENTIAL 1. GOOD ___ 2. FAIR ___ 3. MINIMAL ___ DEGENERATION _____

NURSING EVALUATION (PROCEDURES REQUIRED)

INFECTION/I.V'S: TYPE ___ FREQ ___ DIABETIC URINE TEST ___ TUBE FEEDING ___ UT CARE ___
INHALE THERAPY ___ SUCTION ___ O2 ADMIN ___ RESTRAINTS ___ IRRIGATIONS ___ OSTOMY ___
B/B TRAINING ___ REHAB NURSE ___ DRESSINGS ___ I & O (24 HOURS) ___ POSITIONING ___
SPECIFY FREQUENCY OF NSG PROC REQ _____

ORDERED MEDICATION (INCLUDING DOSE, ROUTE AND FREQUENCY)

SOCIAL SERVICES NEEDS: MONEY MGT ___ COMBATIVE ___ NON-COMPLIANT ___ SELF-ABUSE ___
BIZARRE BEHAVIOR ___ TRAINING PROGRAM ___ OTHER _____

DESCRIBE FUNCTIONAL ASSESSMENT (SELF CARE/WITH ASSISTANCE/TOTAL CARE)

MOBILITY/AMB ___ TRANSFERRING ___ BATHING ___ EATING ___ DRESSING/GROOMING ___
TOILETING ___ OTHER ___
COMMENTS: _____

SIGNATURE _____ R.N. DATE _____

PHYSICIANS STATEMENT: INSTITUTIONAL CARE IS PROVIDED UNDER CLASSIFICATIONS DEPENDENT UPON THE TYPE AND/OR COMPLEXITY OF CARE. SERVICES RENDERED AND THE TIME REQUIRED TO RENDER CARE/SERVICES. THE ATTENDING PHYSICIAN IS REQUESTED TO DESIGNATE THE LEVEL OF CARE NEEDED BY CHECKING THE APPROPRIATE LEVEL BELOW:

- () MAXIMUM CARE (SKILLED NURSING CARE) EFFECTIVE DATE _____
- () MEDIUM CARE (INTERMEDIATE CARE I) EFFECTIVE DATE _____
- () MINIMUM CARE (INTERMEDIATE CARE II) EFFECTIVE DATE _____

SIGNATURE OF PHYSICIAN _____ **DATE** _____ **TEEPHONE NUMBER** _____

PRINTED NAME OF PHYSICIAN _____