GEISINGER HEALTH PLAN

Geisinger

GHP INPATIENT REHABILITATION PRE-CERT WORKSHEET

FAX 570-953-0368

PLEASE FILL OUT COMPLETELY

PLEASE *PRINT* LEGIBLY – USE ONLY STANDARD ABBREVIATIONS WHERE NECESSARY

Admitting Facility: _____ Admitting Rehab Physician:_____

Patient Name: _____ Ins. ID#: _____ DOB: _____

PRE-ADMISSION INFORMATION

IP Diagnoses/Procedures: _____Diagnosis Codes_____

Pertinent PMH: ☐ CAD ☐ CHF ☐ COPD ☐ CVA ☐ DM ☐ DJD ☐ HTN ☐ PVD ☐ Other (please specify)

_____

_____

Past Surgical History: ☐ Amputation ☐ CABG ☐ Joint Replacement ☐ Spinal ☐ Other _____

Prior Level of Function: _____

Patient Lives: ☐ Alone ☐ With Spouse ☐ Other _____

Home: Levels_____ Steps_____ Bedroom on _____Floor Bathroom on _____ Floor

Spouse/Other Able to Care for Member at Home: ☐ Yes ☐ No; If other, please identify _____

Planned Discharge Disposition from IP Rehabilitation: ☐ Home ☐ SNF ☐ ICF ☐ PCF ☐ OP Care ☐ Other

Services Requested: ☐PT ☐OT ☐ST Estimated Length of Stay_____

Requestor's Name (Please print): _____

Requestor's Phone Number: (____)_____ Requestor's Fax Number: (____)_____

MEDICAL STATUS	
Date:	**Remarks:**
***Mental Status**:*	
Alert:	
Oriented (person, place, time):	
Follows Commands (simple, complex):	
Speech:	
Aphasia (receptive, expressive):	
Dysarthria:	
Diet:	
Type (regular, dysphagia type):	
Tube Feedings (PEG, J-Tube):	

Sensation (WNL or altered):	
Skin Integrity:	
Wound Care/locations:	
Respiratory:	
Room Air, Nasal Cannula Liters_____	
Vent:	
Trach:	
Suctioning (frequency):	

NOTES (brief explanation of medical episode or attach History and Physical)

FUNCTIONAL STATUS

I = Independent	Mod I = Modified Independent	SU= Set Up	SPV = Supervision	CG = Contact Guard	MIN = Min Assist	MOD = Mod Assist	MAX = Max Assist	D = Dependent

Date:	**Remarks:**
Bed Mobility:	
Rolling (left, right)	
Sit – Supine ↔	
Transfer:	
Bed (Sit – Stand)	
Toilet	
Ambulation:	
Weight Bearing Status	
Assistance required Distance (in Feet)	
Assistive Device	
Stairs	
Balance:	
Standing	
Sitting	
Motor Status: ROM	
Upper Extremity	
Lower Extremity	
Strength:	
Upper Extremity	
Lower Extremity	
Right Upper Extremity	
Right Lower Extremity	

ADL Status	
Eating	
Grooming	
Upper Extremity Dressing	
Lower Extremity Dressing	
Toileting	
Upper Extremity Bathing	
Lower Extremity Bathing	
Adaptive Equipment	

Orthotic/Prosthetic	

Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.