Network Health Review

Facility Contact Name:	Direct Phone #:	Fax #:

Member Name:	DOB:
Admit Date:	Primary Diagnosis:
Discharge Plan:	Anticipated D/C Date:

Anticipated needs at discharge:
PLOF:
Wt. Bearing Restrictions: Yes/No **Location:** RUE/RLE/LUE/LLE/Other **F/U Appt Date:**

Levels	Ind or Mod I	Set-up or Supv	SBA or CGA	Min A	Mod A	Max A	Dep or Total A

Physical Therapy	Update 1 Date:	Update 2 Date:	Update 3 Date:	Update 4 Date:	Update 5 Date:	Update 6 Date:
Bed Mobility						
Transfers						
Gait Distance & Level of Assist						
Assistive Device						
Number of Stairs & Level of Assist						
Occupational Therapy	Update 1 Date:	Update 2 Date:	Update 3 Date:	Update 4 Date:	Update 5 Date:	Update 6 Date:
Bathing - U Body						
Dressing - U Body						
Bathing - L Body						
Dressing - L Body						
Toilet Transfers						
Toilet Hygiene						
Grooming						
Speech Therapy	Update 1 Date:	Update 2 Date:	Update 3 Date:	Update 4 Date:	Update 5 Date:	Update 6 Date:
A&O level						
Feeding/Diet						

Skilled Nursing			
IV Medication: Y/N/NA	Name:	Freq:	Stop Date:
IV Medication: Y/N/NA	Name:	Freq:	Stop Date:

Wound Care w/Tx in place: Y/N/NA:
Member/Caregiver Teaching: Y/N/NA:

HMO and POS plans underwritten by Network Health Plan. Self-insured plans administered by Network Health Administrative Services, LLC. **3535**-02-0723