Medical Provider Admission Evaluation of Patient From Hospital to Skilled Nursing Facility

Please print NEATLY.
Shade boxes like this: ■
Not like this: ☒ ☝

Patient Last Name: ☐☐☐☐☐☐☐☐☐☐☐ Patient First Initial: ☐

Transferred from: ☐ ☐ ☐

Medical Record/History Number: ***(Only Numbers)*** ☐☐☐☐☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Date of Provider Evaluation: ☐☐ / ☐☐ / ☐☐☐☐ Time of Provider Evaluation: ☐☐ : ☐☐ ☐ AM ☐ PM

Skilled Nursing Facility: ☐ ☐ ☐
☐ ☐ ☐

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1. Was this patient's condition appropriate for your facility? ☐ Yes ☐ No
   What do you understand is (are) the reason(s) for admission to your facility? Shade all that apply.
   - ☐ Debility/Rehabilitation ☐ IV antibiotics ☐ Wound Care ☐ Delirium
   - ☐ End of life care ☐ Respiratory Care ☐ Other _____

   Medical Management of:
   - ☐ Anticoagulation ☐ Diabetes ☐ Infections ☐ Other _____
   - ☐ COPD ☐ Heart Failure ☐ Renal Failure

2. Were any of the following protocols applicable and initiated for the patient? Shade box if yes.

	Applicable	Initiated		Applicable	Initiated
CHF	☐	☐	Diabetes Mellitus	☐	☐
COPD	☐	☐	Delirium	☐	☐
Anticoagulation Therapy	☐	☐	Vancomycin/Gentamycin	☐	☐
Sepsis	☐	☐	Other	☐	☐

3. Did hospital transfer documentation provide adequate information to care for this patient? ☐ Yes ☐ No
   If documentation was not adequate, what needed information was missing? Shade all that apply.
   - ☐ Medications ☐ Oxygen orders ☐ Diet Orders ☐ Instructions for ordered devices
   - ☐ Allergies ☐ Antibiotic stop date ☐ Goal weight ☐ Instructions for when to contact provider
   - ☐ Prognosis ☐ Goals of care ☐ Functional status ☐ Instructions for vascular access devices
   - ☐ Other, please list: _____

   If "Medications" is shaded above, please explain. Shade all that apply.
   - ☐ MAR and discharge summary do not match ☐ Missing current MAR
   - ☐ Missing date/time to discontinue short-term medications ☐ Other, please list: _____

4. Did the hospital transfer documentation provide contact information for the discharging provider? ☐ Yes ☐ No
   If **Yes**, were you able to reach someone if needed? ☐ Yes ☐ No

5. In general, was the patient's condition as you expected? ☐ Yes ☐ No
   If no, was the patient's overall condition better or worse than expected? ☐ Better ☐ Worse
   If worse, which of the following unexpected conditions contributed to that assessment? Shade all that apply.
   - ☐ Deteriorated mental status ☐ Problematic behavior ☐ Tachycardia (>100 bpm) ☐ Bradycardia (<60 bpm)
   - ☐ Hypertension (S>150 mmHg) ☐ Hypotension (S<90 mmHg) ☐ Hypoxia (<90%) ☐ Fever (>100.4 F)
   - ☐ Other _____

6. Were there any significant changes to the patient's plan of care prior to your initial assessment? ☐ Yes ☐ No
   ☐ Change in medications ☐ Blood test ☐ Cultures ☐ X-Rays ☐ Intravenous fluids
   ☐ Provider notified by nursing of change ☐ Other

7. Comments **on reverse side of this form**.

8. Your last name: ☐☐☐☐☐☐☐☐☐☐☐ First Initial: ☐ Credentials: ☐ MD/DO ☐ PA/NP

Adapted with permission from Michele Bellantoni, MD, CMD at Johns Hopkins University School of Medicine. v2 01/2014