

Long Term Care Professional Medical Information

Dear Medical Provider:

The following client is participating in a functional needs assessment to determine appropriateness for long term care services. The functional needs assessment is used to determine if the client meets the nursing facility, ICF/IID or hospital level of care. As a part of the functional needs assessment, a licensed medical professional shall complete this form to certify the client's medical necessity for long term care services.

Client Information Section

Last Name: _____	First Name: _____	Middle Initial: _____
Street Address: _____	City: _____	State: _____ Zip: _____
Date of Birth: _____	Telephone: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

Medical Information Section

ICD Code	ICD Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis? Yes No
 Is there a Traumatic Brain Injury Diagnosis? Yes No
 Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.
 Neurological Exam Date: _____

If Hospitalized, Reason: _____ Admit Date: _____
 Diet Order: _____
 Allergies: _____
 Prognosis: _____

Medical Provider Name: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Name of Person Completing this Information: _____ Date Completed: _____
 Title of Person Completing this Information: _____
 Signature of Licensed Medical Professional Verifying this Information: _____
 Medical Provider Comments: _____

Facility/Case Manager Information

Facility/Case Management Agency: _____
 Administrator/Case Manager Name (print): _____ Phone Number: _____
 Administrator/Case Manager Signature: _____