Jefferson Health Plans | Health Partners Plans

# Concurrent Review Request Form

Patient Name: _____ Member ID: _____

Date of Birth: _____ Dx: _____

Medical HX: _____ Admission Date: _____

PLOF and Living Situation: _____

Estimated Length of Stay: _____

Discharge Plan (Number of hours home alone, if first floor set up possible): _____

Caregiver Training Anticipated Date: _____ Training Needed: _____

Completed: ☐ Yes ☐ No

## Medical Information

| | 1st Update/Date | 2nd Update/Date | 3rd Update/Date | 4th Update/Date |
|---|---|---|---|---|
| **Any Change in Medical Condition** | | | | |
| **IV ABX with Stop Date** | | | | |

## Wounds (Including VAC, Drains)

| Onset | 1st Update/Date | 2nd Update/Date | 3rd Update/Date | 4th Update/Date |
|---|---|---|---|---|
| **Area** | | | | |
| **Stage** | | | | |
| **Measurements** | | | | |
| **Treatment (Please include frequency)** | | | | |

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Please send only current information from lookback period of last review. **Please do not use TBD for discharge plan information.**

| | Week 1 | Week 2 | Week 3 | Week 4 |
|---|---|---|---|---|
| **Ambulation** | | | | |
| **Stairs** | | | | |
| **Bed Mobility** | | | | |
| **Transfers** | | | | |
| **Balance/Standing** | | | | |
| **Feeding** | | | | |
| **Grooming** | | | | |
| **Dressing** | | | | |
| **Bathing** | | | | |
| **Toileting** | | | | |

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