MOLINA HEALTHCARE

Clinical Review Form

MEMBER INFORMATION			
Review Date:	/ /	Reviewer Name:	
Member Name:		Facility Name:	
DOB:	/ /	NPI #	
Authorization Number:		Tax ID #	
Admitting Diagnosis:			
Admit Date:	/ /	Est. D/C Date:	/ /
D/C Plans:			

Please send supporting progress notes

PHYSICAL THERAPY

PT ☐ _____x Per Week Discharged ☐ _____Date Of Discharge

I - Independent MI - Modified Independent S - Supervision CGA - Contact Guard Assist Min - Minimum Assist
Mod - Moderate Assist Max - Maximum Assist Total - Total Assist D - Dependent

Bed Mobility Rolling Supine to Sit	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	**Date of PT Assessment:** _____ **Current Amount of PT:** Minutes/Day _____ Days/Week _____ **Time frame needed to reach these goals:** Predicted Date _____
Transfers Sit to Stand Tub/Shower	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	
Ambulation Distance(Ft)_____ Assistive Device(s)	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	
Prior Living Situation		
Weight Bearing Status		

Additional Comments Pertinent to Therapy PT:
I.e. - ROM/Balance/Endurance/Weight Bearing (LB)/Strength (LB)/Safety

Please send supporting progress notes

OCCUPATIONAL THERAPY

OT ☐ _____x Per Week Discharged ☐ _____Date Of Discharge

I - Independent MI - Modified Independent S - Supervision CGA - Contact Guard Assist Min - Minimum Assist
Mod - Moderate Assist Max - Maximum Assist Total - Total Assist D - Dependent

Feeding	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	Date of OT Assessment: _____ Current Amount of OT: Minutes/Day _____ Days/Week _____ Time frame needed to reach these goals: Predicted Date _____
Grooming	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	
Dressing	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	
Bathing	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	
Toileting	Prior Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D Current Level ☐-I ☐-MI ☐-S ☐-CGA ☐-Min ☐-Mod ☐-Max ☐-Total ☐-D	

Additional Comments Pertinent to Therapy OT:
I.e. - Endurance/Strength/Balance/Homemaking Skills

Please send supporting progress notes

SPEECH THERAPY

ST ☐ _____x Per Week Discharged ☐ _____Date Of Discharge

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Mod - Moderate Assist Max - Maximum Assist Total - Total Assist D - Dependent

Cognitive Abilities Deficit ☐-Yes ☐-No (i.e., CVA) Short-term Memory Safety Awareness	**Aphasia/Dysphasia** ☐-Yes ☐-No **Deficit** Expressive Receptive	Date of Assessment: _____ Current Amount of ST: Minutes/Day _____ Days/Week _____ Time frame needed to reach these goals: Predicted Date _____
Has a modified barium swallowing or TTE evaluation been completed?	Date: _____/_____/_____ Outcome: _____	

Additional Comments Pertinent to Therapy ST:
If cognitive deficit, please describe

NURSING

Abnormal Vitals

Temperature		Respiration		Blood Pressure	/	Pulse	

Respiratory			
Ventilator Weaning	☐-Yes ☐-No	Vent Settings	
FIO2		Mode	
TV		PEEP	
CPAP/BIPAP		CTAC	
Trach	☐-Yes ☐-No		
Suctioning			
Bowel			
Bladder			
Abdomen			
Lungs			
Nutrition			
Current Diet	☐-Mechanical Soft ☐-Tube Feed ☐-NPO ☐-Regular Diet ☐-TPN		
Tube Feed			
Date of Insertion		Frequency	
Formula		Tolerance	
Rate		Residuals	
Hemodialysis			
Onsite		Offsite	
IV Lines			
IV		PICC	
IV		PICC	
IV		PICC	
IV Medications			
#1 Medication		Diagnosis	
Dose / Frequency		Route	
Start Date		Stop Date	
#2 Medication		Diagnosis	
Dose / Frequency		Route	
Start Date		Stop Date	
#3 Medication		Diagnosis	
Dose / Frequency		Route	

Start Date		Stop Date	
#4 Medication		Diagnosis	
Dose / Frequency		Route	
Start Date		Stop Date	
#5 Medication		Diagnosis	
Dose / Frequency		Route	
Start Date		Stop Date	
Abnormal Labs	(Send most recent labs)		
Skin Status			
Wound#1 Location:		Size:	
Description:		Treatment & Frequency:	
Wound #2 Location:		Size:	
Description:		Treatment & Frequency:	
Wound #3 Location:		Size:	
Description:		Treatment & Frequency:	
Wound #4 Location:		Size:	
Description:		Treatment & Frequency:	
Wound #5 Location:		Size:	
Description:		Treatment & Frequency:	

FOLLOW UP PLANNING

Follow Up Appointments:			
#1 Provider Name:		Specialty:	
		Date of F/U:	
#2 Provider Name:		Specialty:	
		Date of F/U:	

#3 Provider Name:		Specialty:	
		Date of F/U:	