

ADDITIONAL DATA ELEMENTS

APPLICANT NAME: _____

APPLICANT CURRENT ADDRESS: _____

AUTHORIZED REPRESENTATIVE, IF ANY _____

INITIAL NF ADMISSION DATE, IF APPLICABLE AND KNOWN: _____

FACILITY NAME, IF CURRENT NF RESIDENT: _____

PROJECTED HOSPITAL DISCHARGE DATE: _____ TIME: _____ IF KNOWN

ESTIMATED LENGTH OF NF STAY:
_____ 0-30 DAYS _____ 31-90 DAYS _____ 91-180 DAYS _____ OVER 180 DAYS

IS PLACEMENT FOR REHABILITATION? CONVALESCENCE?

MEDICATION ADMINISTRATION:
_____ INDEPENDENT _____ NEEDS MEDS SET-UP

_____ NEEDS VERBAL ASSISTANCE _____ NEEDS MEDS ADMIN.

MENTAL/BEHAVIORAL STATUS:
_____ DANGER TO SELF _____ DEPRESSED

_____ DANGER TO OTHERS _____ ABUSIVE

_____ IMPAIRED JUDGEMENT _____ IMPAIRED MEMORY

IN ANSWERING THE FOLLOWING, PLEASE CONSIDER THE APPLICANT'S POTENTIAL FOR RETURNING TO THE COMMUNITY. THIS ASSISTS US IN DETERMINING THE NEED FOR A DELAYED ASSESSMENT.

REHABILITATION POTENTIAL: _____ IMPROVE FUNCTION _____ MAINTAIN FUNCTION
_____ RETARD LOSS OF FUNCTION _____ NONE

PROGNOSIS: _____ GOOD _____ FAIR _____ POOR _____ TERMINAL

BRIEF SUMMARY OF CAPACITY FOR INDEPENDENT LIVING, LEARNING, SELF-DIRECTION AND COMMUNICATION SKILLS:

BRIEF ASSESSMENT OF INFORMAL SUPPORT SYSTEM: