# Continuity of Care

| Name: | | | | | Phone Number: |
|---|---|---|---|---|---|
| Address: | | | | | Social Security No: |
| Sex | Age | DOB | Date Adm: | Date Discharge: | Medicaid No: |

| Attending Physician: | Phone No: |
|---|---|

| Contact Person/Next of Kin: | Relationship: | Phone No: |
|---|---|---|

**Transfer To:**

| Primary Diagnosis: (List only One diagnosis) | Other Diagnosis: |
|---|---|
| | |

**Physician Discharge Orders: (including medications, treatments, dressing changes, therapies, IV's)**

| ADL's | Self | Assist | Total | Level of Care Required | Therapies |
|---|---|---|---|---|---|
| Bathing | | | | ☐ Skilled ☐ Protective | ☐ O.T. freq. _____ |
| Dressing | | | | ☐ Intermediate ☐ MR/DD | ☐ P.T. freq. _____ |
| Grooming | | | | | ☐ S.T. freq. _____ |
| Ambulation | | | | | |
| Toileting | | | | | ☐ Skilled Nursing Services |
| Transfers | | | | | freq. _____ |
| Eating | | | | ☐ NEEDS 24 HR. SUPERVISION DUE TO COGNITIVE IMPAIRMENT | |
| Meds | | | | | |

**Medically Stable:** ☐ Yes ☐ No

**Prognosis:** ☐ Good ☐ Fair ☐ Poor **Rehabilitation Potential:** ☐ Good ☐ Fair ☐ Poor

**Community Support:** ☐ Yes ☐ No **Estimated Length of Stay:** less than 6 months: _____
greater than 6 months: _____

**Mental Status:** ☐ Alert ☐ Forgetful ☐ Agitated ☐ Anxious **Oriented To:** ☐ Person ☐ Place ☐ Time

**Physician Certification:** I certify that I have reviewed the information contained herein, and that the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended above is required.

| Physician Signature: | Date: |
|---|---|
| | |

| Print Name: |
|---|
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