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: