SENIOR WHOLE HEALTH®
Simple. Secure. Independent.

REHAB / CHRONIC / SNF / REFERRALS

Telephone Numbers
Main: (617) 494-5353
(888) 794-7268
Fax: (617) 551-4198

Patient Name:

ID Number: Date of Birth:

Referring MD: And Telephone #:

Acute Facility: Admission Date:

Contact Person: And Telephone #:

Facility Referred To: Date of Evaluation:

Person completing form and facility: And Telephone #:

Type of Request:
1. Rehab ☐ Acute ☐ Respiratory ☐ Pain ☐ Oncology ☐ 2. Chronic ☐ 3. SNF ☐

Any assistive devices, including specialty bed; wound voc:

Social History:
Specify support, primary caregivers and community service prior to admission:

Past Medical History:

Brief History of Present Illness:
Please include all diagnoses, surgeries with date of service, current medications, IVs, respiratory status, pain management, and cognitive status.

If patient has a wound, give Dimensions and Management:

Bed Mobility:	Ambulation:	Bathing:	Dressing LE:
Transfers:	Device:	Bathing LE:	Feeding:
Endurance:	Distance:	Dressing UE:	

KEY:
1=Independent 2=Supervision 3=Contact Guard 4=Minimum Assist 5=Moderate Assist 6=Maximum Assist
7=Dependent NOTE: If assistance is required, please specify number of people required; i.e., Min, Ax1, Max, Ax2, etc.

Goals:

Resp. Rehab
PFT Results: FEV1 Expected: Observed: 02 Depend: Yes ☐ No ☐

Cardiac Rehab
Rejection Fraction: List any Med. Adjustments:

Oncology
Prognosis > 6 months 6 months DNR: Yes ☐ No ☐

Any Current TX?

Expected Length of Stay:
If requested level of care is denied, patient's preferred alternative is:

Comments / Additional pertinent information: