Your Hospital's Logo Here

COMMUNICATION / REQUEST FOR INFORMATION

PATIENT:	ROOM:
PHYSICIAN:	DATE:

This patient record is being reviewed by Case Management. Please note the information and provide Medical Record documentation and/or the needed information in order to ensure accurate review.

_____ Patient **ADMISSION / CONTINUED STAY does not meet InterQual criteria for:**

☐ Severity of illness ☐ Intensity of Service _____ as of _____

Please document medical necessity for: ☐ Admission ☐ Continued acute inpatient stay.

_____ Other: _____

_____

_____ Please review and **sign**
- ☐ **Part B** of the **Long Term Care Referral Form** located in front of chart
- ☐ **Delmarva Medical Eligibility Review Form** located in front of chart.
- ☐ **Home Care Referral Form** located in front of chart, if indicated.
- ☐ **Medicare Authorization for Ambulance Transportation Form**

_____ Dictated Discharge/ Transfer Summary (**Word type 45**) needed by 1500 (3 pm) _____

_____ Other: _____

_____

_____ Anticipated D/C Date: _____

_____ CM / Rehab. Services recommends Home Rehab. for ☐ **PT** ☐ **OT** ☐ **SLP**

_____ Hospital's Rehab. Services recommends ☐ **Acute** ☐ **Subacute Rehabilitation** for this patient.

_____ Will patient require home / continued IV Infusion Therapy? (☐ **Antibiotics** ☐ **TPN** ☐ **PPN**)

Other _____

_____

_____

_____

Thank you for your assistance in facilitating and expediting the best possible Case Management or Discharge Plan for your patient!

THIS FORM IS NOT A PERMANENT PART OF THE PATIENT RECORD

Return to Case Management

Thank you,

_____

Name Title Pager #