HEALTHCARE
Hospital

Patient Name:

Encounter Number:

CASE MANAGEMENT
INITIAL ASSESSMENT FOR PATIENTS FROM A NURSING FACILITY

Date Referred: Assessment Date & Time:

Resident Of:

Diagnosis: DOB: Sex:

Bed Hold Status: Bed Hold expires on :

☐ Medical Assistance (15 Days) ☐ Medicare
☐ Private Pay ☐ Other Insurance

Confirmed with NH: (Name) Date:

Other:

Patient/Family understands possible non-coverage of transportation by insurance ☐ N/A ☐ Patient

Other: (Name)

Additional Information:

Name/Signature: Beeper: Date:

PLEASE DO NOT REMOVE IF CH