CHECKLIST TO DETERMINE NEED FOR INPATIENT REHABILITATION

NOTE: SKILLED THERAPY EVALUATIONS ARE HELPFUL. THE FOLLOWING IS A TOOL TO BE USED BY A NURSE IN ASSESSMENT FOR INPATIENT REHABILITATION NEEDS.

Circle the patient's CMS rehabilitation-qualifying diagnosis		
STROKE	FRACTURE OF LOWER EXTREMITY	CARDIAC
TRAUMATIC BRAIN INJURY	REPLACEMENT OF LOWER EXTREMITY	PULMONARY
NON-TRAUMATIC BRAIN INJURY	OTHER ORTHOPEDIC	PAIN SYNDROME
SPINAL CORD INJURY	AMPUTATION	MULTI TRAUMA
NEUROLOGICAL CONDITIONS	OSTEOARTHRITIS	GUILLAIN BARRE
OTHER_____	RHEUMATOID ARTHRITIS	BURNS

Does the patient currently have therapies ordered?	Physical Therapy (PT)	□YES □NO
	Occupational Therapy (OT)	□YES □NO
	Speech Therapy (SLP)	□YES □NO

CURRENT FUNCTIONAL STATUS	**EATING & SWALLOWING (SLP)**	Does the patient have difficulty managing his/her own secretions?	□YES □NO □Chronic
		Does the patient need assistance with feeding?	□YES □NO □Chronic
		Is the patient coughing or clearing his/her throat during eating or drinking?	□YES □NO □Chronic
		Is the patient having trouble managing food or liquids?	□YES □NO □Chronic
		Is the patient pocketing food in the cheek?	□YES □NO □Chronic
	GROOMING (OT)	Does the patient need assistance with face washing, teeth brushing, or hair combing?	□YES □NO □Chronic
	BATHING (OT)	Does the patient need assistance to bathe?	□YES □NO □Chronic
	DRESSING (OT)	Does the patient need assistance to dress?	□YES □NO □Chronic
	TOILETING (OT)	Does the patient need assistance to manage clothing down and up and/or perform peri-hygiene?	□YES □NO □Chronic
	TRANSFER (OT, PT)	Does the patient need assistance to move from the bed to a chair, the chair to the toilet?	□YES □NO □Chronic
		Does the patient need assistance to get in and out of bed?	□YES □NO □Chronic
		Are there safety concerns when the patient moves?	□YES □NO □Chronic
		Is the patient known to be at risk for falling?	□YES □NO
	WALKING (PT)	Does the patient need assistance to walk safely?	□YES □NO
		Does the patient need assistance to walk household distances (50ft) safely and independently?	□YES □NO □Chronic
	BLADDER & BOWEL MANAGEMENT	Are there any bowel or bladder difficulties? Incontinence? Urinary retention? Constipation?	□YES □NO □Chronic

	COMPREHENSION (SLP)	Does the patient need assistance to follow simple and complex instructions for things like safety, medication management, transfers, etc.?	□YES □NO □Chronic
		Does the patient have new problems with reading?	□YES □NO □Chronic
	EXPRESSION (SLP)	Does the patient need assistance to communicate needs by talking, gesturing and/or writing?	□YES □NO □Chronic
		Does the patient have trouble putting thoughts together or finding the right words?	□YES □NO □Chronic
		Is it difficult for you to understand what the patient is saying? (Slurred speech or voice change.)	□YES □NO □Chronic
	SOCIAL INTERACTION (SLP)	Do people close to the patient notice any changes in how the patient interacts?	□YES □NO □Chronic
		Is there any hemi-spatial neglect? Does the patient neglect people or items to the left or right of midline?	□YES □NO □Chronic
	PROBLEM SOLVING (SLP)	Does the patient need assistance to problem solve through new or different tasks?	□YES □NO □Chronic
	MEMORY (SLP)	Are there any new memory issues noted in either short term or long term memory or learning new information?	□YES □NO □Chronic
RED FLAG SAFETY	Is safety compromised (physical, cognitive, visual, awareness)?		□YES □NO
	Any new comprehension, problem solving or memory issues?		□YES □NO
	Were swallowing difficulties identified above?		□YES □NO
	Was expressive or receptive aphasia identified above?		□YES □NO
	Is the patient only attentive to one side?		□YES □NO
	Does the patient have persistent weakness, tingling or numbness on one side of the body?		□YES □NO
Has there been a significant decrease in level of function from prior to illness/event?			□YES □NO
Was the patient barely managing personal cares prior to this illness/event?			□YES □NO
Is discharge to home anticipated?			□YES □NO
Is family committed to helping patient at discharge if needed?			□YES □NO
Are intensive rehab services are medically necessary as per the primary care provider?			□YES □NO
Is the patient medically stable as per the primary care provider?			□YES □NO
Can the patient tolerate and participate actively in at least 3 hours of therapy/day?			□YES □NO
Is there a need for interdisciplinary services (PT, OT, SLP, nutrition, respiratory, psychology, etc…) including 24/hr rehab nursing?			□YES □NO

Signature_____ Date_____