



Physical Rehabilitation Review Worksheet
for
Concurrent Review

Providers with no access to the Qualis Health Provider Portal may use this form.

Call Date: _____ Caller: _____ Reference # _____

Admit Date: _____

Patient's Name: _____

Medicaid #: _____

Rehabilitation Facility: _____

Phone #: _____

New Procedures: _____ Date: _____

In general, has measurable improvement been documented weekly? Yes No

Indicate:

1. Specific improvement—or lack of improvement—in the following areas, and

2. Revision of goals, if necessary

Improvements

Comments

Cognitive function	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Communication	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Continence, bowels	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Continence, bladder	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Mobility	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Pain management	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Perceptual motor function	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Self-care activities	Y <input type="checkbox"/> N <input type="checkbox"/>	_____



Patient Name: _____

Intensity of Service

Will the progressive therapy program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

- _____ ADLs
- _____ Bed mobility/transfers
- _____ Home lifestyle modifications
- _____ Positioning/splinting
- _____ Pulmonary rehabilitation
- _____ ROM/strengthening
- _____ Speech language retraining
- _____ Swallowing retraining
- _____ Wheelchair mobility/ambulation/balance

If this is an admission trial of 1 week or less, the program will provide:

- _____ At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy
- _____ Full participation in evaluation/therapy
- _____ Rehab evaluations completed within 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this patient? _____

Program Coordination

What is the ongoing needs assessment/procurement? _____

What instruction does the patient require? _____

What is identified as discharge needs, barriers, patient support systems, and patient capabilities? _____



Patient Name: _____

Disposition Planned

1. If goals achieved: _____
2. If goals not achieved: _____

Physiatrist's Plan of Care and Recommendation (if applicable)

Number of days requested _____

Number of days approved _____

Approved until _____

Authorization # _____

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