Your Hospital - CASE MANAGEMENT ABSTRACT

CMC#:

Admission Date:	D/C:
Room #:	Age:
Unit Transfer(s):	
Type of Admission: ☐ ED ☐ Urgent ☐ Elective ☐ Other	
Payor / Insurance:	
Initial CM Review Date:	☐ Teaching Svc ☐ Non-Teaching Svc

PATIENT IDENTIFICATION

INITIAL CLINICAL REVIEW	SI / INTENSITY OF SERVICE (IS) - CLINICAL REVIEW
Admitting Dx:	**Initial Tx:**
Pertinent Hx:	**Treatment Plan / Goals:**
Severity of Illness (SI) - Presenting Symptoms:	**Current / Clinical Issues:**
Labs:	**Target LOS:** **Meds:**
Dx Test / Date: Findings: **Dx Test / Date:** Findings: **Dx Test / Date:** Findings:	**Dx Test / Date:** Findings: **Dx Test / Date:** Findings: **Dx Test / Date:** Findings:
OR / Procedure: Findings: **OR / Procedure:** Findings:	**OR / Procedure:** Findings: **OR / Procedure:** Findings:

DISCHARGE PLANNING DISPOSITION

Mental Status: ☐ Alert ☐ Oriented x _____
☐ Combative ☐ Nonverbal ☐ Other _____

Functional Level: _____

ADMITTED FROM: ☐ Home ☐ Alone ☐ Rehab ☐ NH
☐ Shelter ☐ Group Home ☐ Other _____

Phone #: _____

Facility Name: _____

FAMILY / S.O. CONTACT: Available at D/C ☐ Y ☐ N

Name: _____

Phone #: _____

CURRENT HOME HEALTH SERVICES IN PLACE:

☐ SN ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ HHA
☐ Hospice ☐ Infusion ☐ Other _____

Agency: _____

Equipment: _____

Dialysis Facility: _____

Referral To: ☐ CMC ☐ SW ☐ PCS ☐ Other _____

Reason: _____

Plan / Goals: _____

Comments or D/C Info: _____

Recent Hosp. Admit.: ☐ Y ☐ N When: _____

Referral to Physician Advisory / Date: _____

Reason: _____

Identified QA Issue(s): _____

INSURANCE CO:			**PHONE #:**		
Date:	UR:	Auth.:	Date:	UR:	Auth.:
Date:	UR:	Auth.:	Date:	UR:	Auth.:
Date:	UR:	Auth.:	Date:	UR:	Auth.:
Date:	UR:	Auth.:	Date:	UR:	Auth.:

SI / IS REVIEW - CLINICAL REVIEW

PATIENT: **ROOM:**

SI / IS REVIEW - CLINICAL REVIEW	

PATIENT: **ROOM:**

SI / IS REVIEW - CLINICAL REVIEW	