Department of Health and Human Services
Health Care Financing Administration

Form Approved
CMB No. 0938-0227

UPDATED PLAN OF CARE / PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)

1. PATIENT'S LAST NAME: FIRST NAME: MI:	2. PROVIDER NO: **201890**	3. HICN:
4. PROVIDER NAME: **CMNRC**	5. MEDICAL RECORD NO:	6. ONSET DATE:	7. SOC. DATE:
8. TYPE: **SPEECH & LANGUAGE & DYSPHAGIA**	9. PRIMARY DIAGNOSIS: (Pertinent Medical Dx)	10. TREATMENT DIAGNOSIS: **RESTORATIVE DINING / DYSPHAGIA**	11. VISITS FROM SOC.:
	12. FREQ / DURATION: *(e.g., 3WK x 4WK)*		

13. CURRENT PLAN UPDATE // FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)*

[a] Resident will follow the Safe Swallow Guide with 95% accuracy.

[b] Resident will eat 50% or more of each meal.

OUTCOME *(Long Term)*

Resident will swallow food and liquid safely with minimal to no aspiration risk 90% of the time *(3 meals a day).*

PLAN 1: Resident assigned to the Restorative Dining (RD) Table in the dining room and RD Aid to follow Safe Swallow Training Protocol.

[a] Resident to eat Food Consistency _____ &
Liquid Consistency _____

[b] Resident to use the following Adaptive Utensils: _____

[c] Intake Strategies: _____

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ DC ☐ N/A

14. RE-CERTIFICATION:
FROM THROUGH ☐ N/A

15. PHYSICIAN'S SIGNATURE:	16. DATE	17. ON FILE *(print / type Physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

☐ Resident continues to demonstrate the following Dysphagia Warning Signs: _____

☐ Resident consumes _____ % of most meals. Last month _____ %.

☐ Resident makes effective use of adaptive utensils *(check)* ☐ Independently ☐ Needs Cuing ☐ Full Assistance ☐ Moderate Assistance ☐ Minimal Assistance

☐ Resident maintains appropriate seating posture at meal times _____ % of the time. Last month _____ %.

☐ Resident continues to learn and utilize safe intake strategies _____ % of the time. Last month _____ %.

☐ Other:

19. SIGNATURE (or name of professional, incl. professional designation)	20. DATE:	21. ☐ CONTINUE SERVICES ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period, relate your documentation to functional outcomes & list problems still present.)*

☐ Resident continues to improve with PO intake following the Safe Feeding & Swallow Protocol.

☐ Resident continues is following meal-time strategies *(check)* ☐ Independently ☐ Needs Cuing ☐ Full Assistance ☐ Moderate Assistance ☐ Minimal Assistance

☐ Resident continues to show progress, but has not reached Safe Swallowing Goals and continues to require training at the RD Table.

☐ Resident has reached Safe Swallowing Goals and can begin transition back to his/her home-base table in the Dining Room.

☐ Other:

23. SERVICE DATES:
FROM THROUGH