

Concurrent Review Request Form

Patient Name: _____ Member ID: _____

Date of Birth: _____ Dx: _____

Medical HX: _____ Admission Date: _____

PLOF and Living Situation: _____

Estimated Length of Stay: _____

Discharge Plan (Number of hours home alone, if first floor set up possible): _____

Caregiver Training Anticipated Date: _____ Training Needed: _____

Completed: Yes No

Medical Information

	1st Update/Date	2nd Update/Date	3rd Update/Date	4th Update/Date
Any Change in Medical Condition				
IV ABX with Stop Date				

Wounds (Including VAC, Drains)

Onset	1st Update/Date	2nd Update/Date	3rd Update/Date	4th Update/Date
Area				
Stage				
Measurements				
Treatment (Please include frequency)				

Please send only current information from lookback period of last review. **Please do not use TBD for discharge plan information.**

	Week 1	Week 2	Week 3	Week 4
Ambulation				
Stairs				
Bed Mobility				
Transfers				
Balance/Standing				
Feeding				
Grooming				
Dressing				
Bathing				
Toileting				