Long Term Care Professional Medical Information

Dear Medical Provider:
The following client is participating in a functional needs assessment to determine appropriateness for long term care services. The functional needs assessment is used to determine if the client meets the nursing facility, ICF/IID or hospital level of care. As a part of the functional needs assessment, a licensed medical professional shall complete this form to certify the client's medical necessity for long term care services.

Client Information Section

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____ Male ☐ Female ☐

Medical Information Section

ICD Code	ICD Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis? Yes ☐ No ☐
Is there a Traumatic Brain Injury Diagnosis? Yes ☐ No ☐
Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.

Neurological Exam Date: _____

If Hospitalized, Reason: _____ Admit Date: _____

Diet Order: _____
Allergies: _____
Prognosis: _____

Medical Provider Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Person Completing this Information: Date Completed:

Title of Person Completing this Information:

Signature of Licensed Medical Professional Verifying this Information:

Medical Provider Comments:

Facility/Case Manager Information

Facility/Case Management Agency: _____
Administrator/Case Manager Name (print): _____ Phone Number: _____
Administrator/Case Manager Signature: _____