MAP-726A
Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

Resident Name _____Medicaid # _____-_____-_____

Room # _____ Room Certified for Medicaid ☐ Yes ☐ No

If Pending Medicaid, Social Security # _____-_____-_____

Medicare # _____ Date of Birth _____/_____/_____

Marital Status ☐ M ☐ W ☐ S ☐ D ☐ Male ☐ Female

Responsible Party _____

Responsible Party Address _____

Relationship _____

Diagnoses _____

_____

_____

Living Arrangements Prior To Admission _____

_____

CHECK ONE ONLY:

☐ New Admit Date _____/_____/_____

☐ Readmit Date _____/_____/_____

☐ Pay Source Change Date _____/_____/_____

(Last Admit Date _____/_____/_____)

Admission or Readmission From:	
Acute Care Hospital	
Free-Standing Psychiatric Hospital	
Home	
ICF/MR/DD	
Nursing Facility	
Personal Care Home	
Other:	

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

***PASRR LEVEL I FORM (AND IF APPLICABLE, THE LEVEL II FORM) MUST BE COMPLETED AND A COPY FAXED WITH ALL NEW ADMISSIONS AND ALL PAY SOURCE CHANGES.**

Level I PASRR Date _____/_____/_____ Completed By _____

Level II PASRR Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Verbal Determination Form
(Mental Illness Only) Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Inappropriate Referral Date _____/_____/_____ Completed By _____

NF Name	Facility ID # Phone ( )
Physician Name Address	Physician Phone ( ) Fax # ( )
Physician License #	
MEDICATIONS	
Describe resident's medications: Number of Oral, Tube, Topical, Inhalers, Sprays, or Patches. List the name and frequency of any IV, SQ, or IM medications (include routine flushes), Routine Administration of Oxygen (i.e., new administration of oxygen or regulating oxygen, how often checking pulse oximetry, etc.) and Nebulizer Treatments.	

Is resident capable of self-administering medications? ☐ Yes ☐ No If no, why_____

_____

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

COGNITIVE ABILITIES

Comatose	Y N	If Yes, Proceed to Communication
Memory Recall:		
Knows Own Name	Y N	Comments:
Knows Date/Time	Y N	Comments:
Knows Location	Y N	Comments:
Knows Staff	Y N	Comments:

COMMUNICATION /HEARING ABILITIES

Hears Adequately	Y N	Uses Speech to Communicate	Y N	Comments:
Hearing Aid Use	Y N	Understands Verbal Direction	Y N	Comments:

VISION PATTERNS

Vision Adequate	Y N	Comments:
Visual Limitations	Y N	Comments:

MOOD AND BEHAVIOR

Wanders	Y N	Comments:
Physically Abusive	Y N	Comments:
Verbally Abusive	Y N	Comments:
Socially Inappropriate	Y N	Comments:
Resists Care	Y N	Comments:

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

ACTIVITIES OF DAILY LIVING

Bed Mobility :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Bedbound ☐ Yes ☐ No

Transfer :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
To/From ☐ Bed ☐ Chair ☐ Wheelchair
How often requires assist? _____

Ambulation :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Standby assist ☐ Yes ☐ No
How often requires assist? _____
Independent with device ☐ Yes ☐ No
Wheelchair per self ☐ Yes ☐ No
Wheelchair assist ☐ Yes ☐ No
How often requires assist? _____

Bathing :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Standby assist ☐ Yes ☐ No
How often requires assist? _____
☐ Back ☐ Arms
☐ Legs ☐ Hands
☐ Feet

Dressing :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Pulling on pants ☐ Putting on shirt
☐ Buttons, Zippers ☐ Prothesis
How often requires assist? _____
☐ Continuous Supervision/Cues

Grooming :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Hair ☐ Nails
☐ Teeth ☐ Shaving
☐ Makeup
How often requires assist? _____
☐ Continuous Supervision/Cues

Toileting :
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Pericare ☐ Adjust Clothing ☐ On/Off Toilet
☐ Changing pads/briefs ☐ Manage ostomy/catheter
How often requires assist? _____
☐ Continuous Supervision/Cues

ADL Comments

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

NUTRITIONAL STATUS

Type of Diet	☐ Regular ☐ Low Sodium ☐ Healthy Heart ☐ Other
Height	Weight
Feeding	☐ Independent with Tray Set Up ☐ Receives Partial Hands on Assist to Eat ☐ Total Feed ☐ Continuous Verbal Cues
Tube Feeding Required	☐ Yes ☐ No If Yes, Explain Amount _____ Brand_____ Frequency _____ H20 Flushes & Frequency _____

SKIN CONDITIONS

	Stage 1	Stage 2	Stage 3	Stage 4
Number of Decubitus Ulcers				
Type of Ulcer	Pressure/Stasis	Pressure/Stasis	Pressure/Stasis	Pressure/Stasis
Treatment				
Other Skins Problems				
Treatment				

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

THERAPIES

Physical Therapy	Y N	Days Per Week:	Comments:
Occupational Therapy	Y N	Days Per Week:	Comments:
Speech Therapy	Y N	Days Per Week:	Comments:
Respiratory Therapy	Y N	Days Per Week:	Comments:

NURSING REHABILITATION/RESTORATIVE CARE

a. Range of Motion (Passive)	Y N	Days Per Week:	Comments:
b. Range of Motion (Active)	Y N	Days Per Week:	Comments:
c. Splint or Brace Assistance	Y N	Days Per Week:	Comments:
d. Bed Mobility	Y N	Days Per Week:	Comments:
e. Transfer	Y N	Days Per Week:	Comments:
f. Walking	Y N	Days Per Week:	Comments:
g. Dressing or Grooming	Y N	Days Per Week:	Comments:
h. Eating or Swallowing	Y N	Days Per Week:	Comments:
i. Amputation/Prosthesis Care	Y N	Days Per Week:	Comments:
j. Communication	Y N	Days Per Week:	Comments:
k. Toileting	Y N	Days Per Week:	Comments:

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

Additional Safety/Health Information Pertinent to Admission (i.e., Wanderguard, bed/chair alarm, locked unit/building, full side rails, etc.)

PLEASE FAX **ALL PASRR** INFORMATION WITH **NEW ADMISSION** REQUESTS.

I certify that the MAP-726A information was reviewed by me. I attest that the foregoing information is true, accurate and complete.

_____/_____/_____
RN/LPN Signature Date

/ /
Person Faxing Request Date

( ) ( )
Telephone Number Fax Number