OPTUM Care® | Network of Arizona

Direct admit to SNF request form

Patient:	
Name:	Date of birth:
Height:	Weight:
HIC#:	Policy ID#

Skilled nursing facility:	
SNF:	Contact:
Address:	
Phone:	Fax:

Orders:		
Skilled need:		
Prior level of function:		
Allergies:		
Diet:	Code status:	O2 needs:
Tuberculosis screening:		
SNF can administer PPD or CXR at time of admit: ☐ YES ☐ NO		Confirmed by:
Free of TB:	CXR date:	PPD date:

Therapy evaluate and treat:	☐ Physical	☐ Occupational	☐ SLP
Patient/Responsible party is aware of condition:		☐ Yes	☐ No
May have flu vaccine if not allergic to eggs:		☐ Yes	☐ No
May have Pneumovax:		☐ Yes	☐ No
May have annual PPD/CXR:		☐ Yes	☐ No
May crush medications & open capsules PRN:		☐ Yes	☐ No
May give medications with jelly or food:		☐ Yes	☐ No
May use generic medications unless otherwise stated:		☐ Yes	☐ No
May discontinue PRN medications not used in 7 days:		☐ Yes	☐ No

Additional miscellaneous orders or treatments:

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Patient's name: _____ DOB: _____ / _____ / _____

Narcotic prescriptions need to follow DEA and state law requirements.

Active medications:			
Medication	**Purpose**	**Dosage/route**	**Frequency**

If not listing medication(s) above, check box and attach signed/dated medication list.

☐ Signed and dated medication list attached

☐ Please accept H&P as current

_____

Physician printed name

_____

Physician signature / date