STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

BEAS 277
09/2020

UTILIZATION REVIEW FORM

To be completed by Registered Nursing Staff

NAME OF NURSING FACILITY:_____ **RECIPIENT NAME:** _____

PRIMARY DIAGNOSIS: _____ **DOB:**_____**Age:**_____

ATTENDING PHYSICIAN:_____ **MEDICAID ID #:** _____

NAME OF PERSON COMPLETING FORM:_____ **DATE:**_____

DATE SPAN REQUESTED:_____

ADL PERFORMANCE SCALE

0. **Independent** – No help or oversight
1. **Supervision** – Oversight, encouragement or cueing provided
2. **Limited Assistance** – Individual highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance.
3. **Extensive Assistance** – While individual performed part of activity, help of the following types(s) provided 3 or more times: Weight bearing support
4. **Total Dependence** – Full staff/caregiver performance of activity

Functional Status (Code level using Performance Scale)

Bed Mobility _____ Bathing _____ Dressing _____

Eating _____ Toileting _____ Transfer _____

Ambulating:_____

SPECIAL EQUIPMENT SCALE

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two + person physical assist
8. Activity did not occur during entire 7 days

Special Equipment (Code level using Spec. Equip. Scale)

Hoyer Lift _____ Power Chair _____ Prosthesis _____

Side Board _____Walker _____ Wheel Chair _____

Mobility (Indicate level using Equipment Scale)

Adaptive Equipment _____ Stair Climbing _____

Walking _____ Wheeling ____

Rehabilitative Services:
1) Attach the Service Summary Sheet
2) Place an "I' for improved or "N" for not improving in the Results column

Condition	Chronic	Acute	Freq Per Wk	Results Improved/Not
PT				
OT				
Speech				

Impairment/Disabilities	None	Partial	Total	Location
Amputation				
Contracture				
Fracture				
Hearing				
Joint Motion				
Loss of Sensation				
Paralysis				
Speech				
Vision				

Medication: Attach a complete list of current medications.

Is the Patient able to understand and adhere to medication regimen? Yes ____ No ____

Special Care	Type	Location	TX Plan
Dressings			
Irrigations			
Tube Feeding			

Wound	STAGE			

	No Issue	Incontinent	Ostomy	Catheter
Bowel Habits				
Bladder Control				

If Problem Behaviors are identified, submit the following:

Behavior Plan Behavior Summary
Memory Behavior Check List Psychiatric eval or note

Reason for continued stay:

_____

_____

_____