

Skilled Nursing Facility (SNF) Re-Hospitalization Risk Assessment

Date: _____ **Anticipated Date of Discharge:** _____

Patient Name: _____ **Primary Physician:** _____

PRIOR PATTERN—Patient has had:

<input type="checkbox"/> >1 hospital or emergency room (ER) visit in the past three months	<input type="checkbox"/> An intensive care unit (ICU) utilization during stay
<input type="checkbox"/> An acute care length of stay (LOS) \geq 7 days	

ACTIVE/CHRONIC CONDITIONS—Patient has:

<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Renal failure
<input type="checkbox"/> Sepsis	<input type="checkbox"/> Traumatic brain injury

RISK FACTORS—Patient has (or is):

<input type="checkbox"/> >2 active comorbid conditions	<input type="checkbox"/> \geq 2 advance care needs (e.g., Trach, IV, colostomy)
<input type="checkbox"/> Non-compliant with disease management	<input type="checkbox"/> A poor prognosis
<input type="checkbox"/> Poor pain control	<input type="checkbox"/> A short life expectancy
<input type="checkbox"/> A history of falls	<input type="checkbox"/> Poly-pharmacy—takes \geq 7 meds
<input type="checkbox"/> Psychiatric /behavioral issues	<input type="checkbox"/> Non-compliant with medication regimen
<input type="checkbox"/> A home safety risk	<input type="checkbox"/> Dyspnea
<input type="checkbox"/> Utilizing an opioid, diabetic agent, and/or blood thinner	

Total number of boxes checked: _____

Five or more boxes **checked** indicates the patient is at high risk for re-hospitalization.