Harmony Healthcare INTERNATIONAL

Interdisciplinary Team Meeting Form

Skilled Functional Reporting and Discharge Planning

Patient Name:			Insurance:	
Date of Admission: ____/____/____			Today's Date: ____/____/____	
Anticipated Last Covered Day of Medicare Part A: ____/____/____				
Enter Key Code for:				
Usual Performance of Functional Status (Review Dates ____/____/____ Through ____/____/____)	Eating:		Toilet Transfer:	
	Oral Hygiene:		Walk 50' with 2 Turns?	
	Toilet:		Walk 150'?	
	Sit to Lying:		Does Resident Use a Wheelchair/Scooter?	
	Lying to Sitting on Side of Bed:		If yes, Type:	
	Sit to Stand:			
	Chair/Bed to Chair Transfer:		If yes, Wheel 150'?	
Key Coding	Independent:	06	Not Applicable:	09
	Set Up or Clean Up Assistance:	05	Partial/Moderate Assistance:	03
	Supervision or Touching:	04	Substantial/Maximal Assistance:	02
	Resident Refused:	07	Dependent	01
	Not Attempted Due to Medical Condition or Safety Concern:			88
Check box if barrier present:				
Barriers to Discharge	Cognitive:	☐	Physical/Home:	☐
	ADL:	☐	Medication Management:	☐
	Mobility:	☐	Other:	☐
	Other:			
Enter Key Code for:				
Performance of Functional Status Goals	ADL: Eating		Transfers	
	ADL: Grooming/ Hygiene		Ambulation (up to 50'-150')	
	ADL: Toileting		Wheel Chair Mobility (up to 150')	
	Bed Mobility (incl: subtasks)		Other:	
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Check box if goal within plan of care:				
Nursing/Medical Management Goals	Medication Management:	☐	Wound Care:	☐
	Diabetes:	☐	Resp./O2 Management:	☐
	Injection:	☐	Resident Education:	☐
	IV Care/Infusion:	☐	Pain Management:	☐
	Other:	☐		
Check box if applicable:				
Service and Equipment Needs for Discharge	Wheelchair:	☐	Raised Toilet Seat:	☐
	Walker:	☐	Tub Chair or Bench:	☐
	Specialty Bed:	☐	Post- Acute Services:	☐
	Commode:	☐	Referral:	☐
	Home Evaluation:	☐	Safe Transitional Plan Reported:	☐
	Other:			

Other	Comments:
Additional Needs:	

IDT Member Signatures/ Credentials	1.	4.
	2.	5.
	3.	6.

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