STATE OF HAWAII
Department of Human Services

Med-QUEST Division
Medical Standards Branch

PATIENT EVALUATION FOR RE-ADMISSION TO ICF-MR

Section I: To Be Completed By Attending Physician

NAME: _____

BIRTHDATE: _____

ACUTE FACILITY TO WHICH ADMITTED:

Name: _____

Admission Date: _____

Diagnosis: _____

_____

_____

_____

Discharge Date: _____

I have evaluated the patient medically and psychologically and conclude that he/she meets the criteria for ICF-MR care. The previous care plan should remain in effect:

With Changes: _____ **Without Changes:** _____

Comments: _____

_____

_____

_____ _____

Physician's Signature **Date**

Section II: To Be Completed By DHS Staff

DHS Decision: **Approved** _____ **Denied** _____ **Deferred** _____ **Effective Date** / /

_____ _____

Med-QUEST Consultant **Date**

DHS 1150A (Rev. 01/96)