# Facility Weekly Update Form

HealthSpring℠

**Fax this completed form to 855-662-7969.**

Member name _____ Date / /

## Nursing services required

Provider order changes this week _____ Last provider visit at this facility _____

Wounds ☐ Yes ☐ No If yes, please complete Wound Documentation Form. Daily dressing change ☐ Yes ☐ No

Number of wounds _____ Time required for wound care _____

Daily injection ☐ Yes ☐ No Medications _____

Diabetic ☐ Yes ☐ No Sliding scale _____ Dialysis _____

Congestive heart failure ☐ Yes ☐ No Chronic obstructive pulmonary disease ☐ Yes ☐ No

If yes, oxygen needs _____

Depression ☐ Yes ☐ No Medications _____

**Is**olation/active infection _____ Blood transfusion _____

PEG tube _____ Changes in weight _____

Respiratory therapy provided _____ Number of days _____

Foley catheter _____

IV therapy _____ Type of fluid/antibiotic _____ Flow rate _____ IV pump ☐ Yes ☐ No

Type of venous access ☐ Peripheral ☐ Port-a-cath Frequency of dressing changes _____

Therapy services provided (check applicable) ☐ PT ☐ OT ☐ SLP ☐ NONE

Total daily hours of skilled care Therapy _____ Nursing _____

Tentative discharge date _____ Barriers _____

Discharge plans _____

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