IDT Checklist

1. Pre-Admission

- ☐ Hospital H&Ps – ER, Inpatient
- ☐ Discharge summary
- ☐ Diagnosis list
- ☐ Medication administration records – schedules, PRN, discontinued (all routes)
- ☐ Respiratory therapy records
- ☐ IV fluid/tube feeding records
- ☐ Transfusion records
- ☐ Flow charts – I & O, VS, nutritional intake
- ☐ Surgical reports
- ☐ All lab reports
- ☐ All radiology reports
- ☐ MRI/PET/CT reports
- ☐ Pathology reports
- ☐ Physician progress notes
- ☐ Nursing assessment and notes
- ☐ Specialist consult reports
- ☐ Wound assessment/report/notes
- ☐ Dietary assessment/notes
- ☐ Social services assessment/notes
- ☐ PT/OT/SLP documentation

Use of the above documentation: diagnoses, medical history, surgical history, care planning, MDS completion, medication reconciliation, drug regimen review, infection control, discharge planning

2. Upon Admission

- ☐ Full name
- ☐ DOB
- ☐ Medicare number
- ☐ Gender
- ☐ Height and weight
- ☐ Why is the patient needing skilled care? Specific illness or injury
- ☐ Admission and IDT assessments
- ☐ Allergies
- ☐ Medical equipment needed
- ☐ Query physician or extender for any additional diagnoses or more specific diagnoses
- ☐ Reconcile medication list/completed drug regimen review
- ☐ Advanced directives
- ☐ Prior living arrangements
- ☐ Prior level of function
- ☐ Prior device use for daily activities
- ☐ Emotional needs/concerns
- ☐ Behavioral/adjustment concerns
- ☐ Facility consent forms
- ☐ Discharge plans and goals
- ☐ Baseline care plan development

The patient's full name, DOB, Medicare number, and gender will be used to verify accuracy of medical record information. Triple check.

The remaining Upon Admission items, excluding the Baseline care plan development, will be used for care plan development and discharge planning.

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