LTC ICD-10 Diagnoses Worksheet

Patient Name:_____________________________   Admission Date:_____________ Doctor________________
DOB________________ Payor _______________________ Transfer Hospital ____________________________

**Diagnoses:** The Admission Nurse shall list the diagnoses in the order of Medicare/HMO coverage priority starting with Primary Diagnosis. The Medical Records Designee shall code the diagnoses listed, assuring accuracy to the 7th character if necessary. **SNF are subsequent encounters only, no A = initial acute encounters (hospital).**

**ADMITTING DIAGNOSIS (Principal):**

1. ___________________________________________________________________   ____________
   (Name of Infection) No initial encounters are to be used

2. ___________________________________________________________________   ____________
   (Type of fracture or Replacement) No initial encounters are to be used

3. ___________________________________________________________________

4. **Rehab- Treatment code M62.81 (MUST INCLUDE ON ALL ADMISSIONS)**

**CURRENT DIAGNOSES:** (only list DX that are in H&P/Discharge Summary; falls and mental dx are last, **do not include constipation**)

**PLEASE ONLY WRITE DOWN DIAGNOSIS (narrative), NOT THE ICD10 CODE**

5. ___________________________________________________________________

6. ___________________________________________________________________

7. ___________________________________________________________________

8. ___________________________________________________________________

9. ___________________________________________________________________

10. ___________________________________________________________________

11. Dementia with behavioral disturbance OR Depression OR mood disorders, etc.
12. S/P fall is always coded last Z91.81

Admission Nurse_______________________________                   Date_____________________________