

LTACH Assessment Form

For long-term acute care hospitals (LTACHs)

Member name: _____
Contract number: _____

C CLINICAL INFORMATION

Height:	Weight:	BP:	HR:	Resp rate:	Temp:
Bowel:				Bladder:	
Oximetry:	Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No			Venti mask / liters:	NC / liters:
Mode:	Rate:		TV:	PEEP:	FiO2:
Vent weaning progression:				Vent wean date:	
<input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP How long: _____			Oxygen saturation response: _____		
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Date inserted: _____			Decannulation trial: _____		
CXR stable / improving? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
<input type="checkbox"/> Chest physiotherapy. Frequency: _____			<input type="checkbox"/> Nebulizer treatments. Frequency: _____		
<input type="checkbox"/> Oxygen adjustments (based on oximetry). Frequency: _____					
<input type="checkbox"/> Suctioning. Frequency: _____ Color: _____			Amount: _____		
Cardiac rhythm / telemetry? <input type="checkbox"/> Yes <input type="checkbox"/> No _____				NYHA class <IV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Neurologically stable last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Continuous sedation / paralytic infusions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				A&O x _____	

LABS / Most current	Hct:	Hgb:	Date:	Stable: <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood products: <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood sugar range:			Glucometer check frequency:		Coverage:
Pertinent labs and cultures: _____					

Isolation? Yes: Type: _____ No

DIET / Type: <input type="checkbox"/> NPO <input type="checkbox"/> TF <input type="checkbox"/> TPN <input type="checkbox"/> Oral	Amount of feeding:	Duration:
For TF -- Formula: _____	/ Route: <input type="checkbox"/> NG <input type="checkbox"/> PEG <input type="checkbox"/> J Tube <input type="checkbox"/> Dobhoff / Corpak®	
Diet: _____		

PAIN: No: Move to "Medications, IVs" questions Yes: Answer the other questions about pain

Pain location: _____

Pain meds (route): _____

Initial pain rating (out of 10): _____ Pain relief: Yes No Rating (out of 10): _____

MEDICATIONS, IVs

Invasive lines: _____

IV medications: _____

Dialysis: No Yes: (a) Acute Chronic HD Peritoneal (b) Frequency: _____ (c) Access: _____

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C CLINICAL INFORMATION (continued)

SKIN / Intact? Yes No: If not intact, answer the remaining questions about the member's wounds / incisions.

WOUND / INCISION #1: Stage: I II III IV Not able to be staged **Size - L x W x D (cm):**

Description:

Treatment: **Frequency:**

WOUND / INCISION #2: Stage: I II III IV Not able to be staged **Size - L x W x D (cm):**

Description:

Treatment: **Frequency:**

Specialty bed: No Yes: Type _____

Wound VAC: No Yes: Wound VAC provider name: _____

Wound debridement: No Yes: Date: _____

HBO: No Yes: HBO provider name: _____

*** To add more clinical information, use the space provided in Section F, on the last page of this form. ***

D REHABILITATION THERAPY

--- PHYSICAL THERAPY ---

Bed mobility:

Transfers:

Ambulation: **Distance:** **Assistive devices:**

--- OCCUPATIONAL THERAPY ---

Feeding: **Grooming:**

Bathing -- Upper body: **Lower body:**

Dressing -- Upper body: **Lower body:**

Toileting / hygiene: **ADL / toilet transfers:**

--- SPEECH / LANGUAGE THERAPY ---

Dysphagia evaluation Modified barium swallow results: _____

Risks / recommendations:

E DISCHARGE PLANS

Discharge date (tentative / actual): **Discharge to:**

ALOC: SNF LTC Adult foster care Assisted living Senior independent living Other _____

Contact person at discharge:

Contact phone number at discharge:

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F

CLINICAL INFORMATION (continued)

Additional comments: