

	Today's date:
וב	□ Precertification
	□ Recertification

Complete this form and fax it to: 1-844-869-4073

Include hospital admission H&P, any PM&R consultation notes, last two days of physician progress notes (admission and concurrent) and current IV and SQ medication lists.

MEMBER and LTACH INFORMATION		
MEMBER name:	DOB:	Age:
Contract number:	Current phone number	:
Resides: □ Alone □ With spouse □ With other		
Home description (steps to enter, levels, bed / bath location	ı, etc.):	
Support: ☐ Spouse ☐ Children ☐ Family/friends ☐ Other		
Comments:		
Acute hospital name:		
Contact at hospital: Name:		-
LTACH name:	LTACH admission	n date:
LTACH contact name:	LTACH phone:	
LTACH reviewer for updates:	LTA CIL mandannam	£a
LTACH reviewer phone number: LTACH admitting physician (first name / last name):	LTACH reviewer	tax:
LTACH ADMITTING DIAGNOSIS		
Acute diagnosis with synopsis of acute hospital admission	(including pertinent radio	ology results) and ty:
Acute diagnosis with symposis of doute hospital admission	(morading pertinent radio	orogy results, and the
Past medical history:		
rast medical history.		
Surgeries / procedures and dates:		



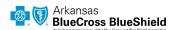
Member name:	
Contract number:	

CLINICAL INFORMATION				
Height: Weight:	BP:	HR:	Resp rate:	Temp:
Bowel:			Bladder:	
Oximetry:	Vent: ☐ Yes ☐	No	Venti mask / liters:	NC / liters:
Mode:	Rate:	TV:	PEEP:	FiO2:
Vent weaning progression:				Vent wean date:
□ CPAP □ BiPAP How long:			Oxvoen saturatio	n response:
Tracheostomy: ☐ Yes ☐ No			Decannulation trial:	
CXR stable / improving?				
				requency:
☐ Oxygen adjustments (based	-			
•				ount:
Cardiac rhythm / telemetry?				
Neurologically stable last 24				
Continuous sedation / paralyt				·
LABS / Most current Hct:				Blood products: Yes No
Blood sugar range:	Glucom	eter check fre	quency:	Coverage:
Pertinent labs and cultures:				
Isolation? ☐ Yes: Type:				□ No
DIET / Type: NPO TF		unt of feeding:		Duration:
1		_		i □ J Tube □ Dobhoff / Corpak
Diet:			Noute. and area	a boblion / Corpak
PAIN: ☐ No: Move to "Medications	 s_IVs" questions □ Y	es: Answer the o	ther questions about pair	1
Pain location:	5, 175 questions = 1	cs. / triswer trie o	and questions about pair	•
Pain meds (route):				
Initial pain rating (out of 1	0):	Pain relie	f: ☐ Yes ☐ No Rating	g (out of 10):
MEDICATIONS, IVs				
Invasive lines:				
IV medications:				



Member name:	
Contract number:	

	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 a				
	Description:	2.0 to 20 stages			
	Description:				
	Treatment:	Frequency:			
	WOUND / INCIDION #0: Of a real D. I. D. II. D. III. D. IV. D. V.	III to be a first of the Mac D family			
	WOUND / INCISION #2: Stage: 🗆 I 🗆 II 🗆 III 🗀 IV 🗆 Not a	ble to be staged Size - L x w x D (cm):			
	Description:				
	Treatment:	Frequency:			
	nouthont.	i roquonoy.			
	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 r	provided in Section F, on the last page of this form. ***			
$ \mathbf{D} $	REHABILITATION THERAPY				
	PHYSICA	L THERAPY			
	Bed mobility:				
	Transfers:				
	Ambulation: Distance:	Assistive devices:			
	OCCUPATIO	NAL THERAPY			
	Feeding:	Grooming:			
	Bathing Upper body:	Lower body:			
	Dressing Upper body:	Lower body:			
	, ,	ADL / toilet transfers:			
	Toileting / hygiene:	BUAGE THERAPY			
	☐ Dysphagia evaluation ☐ Modified barium swallow re	SUITS:			
	Risks / recommendations:				
Ε	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:				



Member name:	
Contract number:	

-	CLINICAL INFORMATION (continued)
_	Additional comments: