Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

LTACH Assessment Form
For long-term acute care hospitals (LTACHs)

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.

A

Today's date:
❑ **Precertification**
❑ **Recertification**

B

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, etc.):

Support: ❑ Spouse ❑ Children ❑ Family/friends ❑ Other____________________
Comments:

Acute hospital name: ____________________ Acute hospital admission date: ____________
Contact at hospital: Name: ____________________ Phone: ____________

LTACH name: **LTACH admission date:**
LTACH contact name: **LTACH phone:**
LTACH reviewer for updates:
LTACH reviewer phone number: **LTACH reviewer fax:**
LTACH admitting physician (first name / last name):

LTACH ADMITTING DIAGNOSIS
Acute diagnosis with synopsis of acute hospital admission (including pertinent radiology results) and tx:

Past medical history:

Surgeries / procedures and dates:

continued on page 2

Revised August 2015

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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:** ❑ Yes ❑ No **Venti mask / liters:** **NC / liters:**
Mode: **Rate:** **TV:** **PEEP:** **FiO2:**
Vent weaning progression: **Vent wean date:**

❑ **CPAP** ❑ **BiPAP** How long:________________ Oxygen saturation response: ________________
Tracheostomy: ❑ Yes ❑ No **Date inserted:** **Decannulation trial:**
CXR stable / improving? ❑ Yes ❑ No ________________
❑ **Chest physiotherapy. Frequency:**________________ ❑ **Nebulizer treatments. Frequency:**________________
❑ **Oxygen adjustments (based on oximetry). Frequency:**________________
❑ **Suctioning. Frequency:**________________ **Color:** ________________ **Amount:** ________________
Cardiac rhythm / telemetry? ❑ Yes ❑ No ________________ **NYHA class <IV?** ❑ Yes ❑ No ❑ N/A
Neurologically stable last 24 hours? ❑ Yes ❑ No ________________
Continuous sedation / paralytic infusions? ❑ Yes ❑ No ❑ N/A **A&O x** ______

LABS / Most current **Hct:** **Hgb:** **Date:** **Stable:** ❑ Yes ❑ No **Blood products:** ❑ Yes ❑ No
Blood sugar range: **Glucometer check frequency:** **Coverage:**
Pertinent labs and cultures:

Isolation? ❑ Yes: Type:________________ ❑ No

DIET / Type: ❑ NPO ❑ TF ❑ TPN ❑ Oral **Amount of feeding:** **Duration:**
For TF -- Formula: ________________ **/ Route:** ❑ NG ❑ PEG ❑ J Tube ❑ 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: ________________

continued on page 3

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

LTACH Assessment Form
For long-term acute care hospitals (LTACHs)

Member name:
Contract number:

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:

continued on page 4

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

LTACH Assessment Form
For long-term acute care hospitals (LTACHs)

Member name:

Contract number:

F

CLINICAL INFORMATION (continued)

Additional comments: