BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

LTACH Assessment Form

Complete this form and fax it to:

1-866-422-5120

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

Today's Date:
☐ **Precertification**
☐ **Recertification**

1. Member and LTACH Information	
Member Name:	Date of Birth:
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 Admitting Physician (First Name / Last Name):
LTACH Contact Name:	LTACH Admission Date:
LTACH Reviewer for Updates:	LTACH Phone Number:
LTACH Reviewer Phone Number:	LTACH Reviewer Fax:

LTACH Admitting Diagnosis

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

Past Medical History:

Surgeries / Procedures and dates:

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Member Name:	
Contract Number:	

2. Clinical Information	
Height:	Weight:
BP:	HR:
Respiratory Rate:	Temperature:
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: 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:
3. Labs (Most Current)	
Hct:	Hgb:
Date:	Stable: ☐Yes ☐No
Blood Products: ☐Yes ☐No	Blood sugar range:
Glucometer check frequency:	Coverage:
Isolation? ☐Yes ☐No Type:	
Pertinent labs and cultures:	

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Contract Number:

4. Diet	
Type: ☐ NPO ☐ TF ☐ TPN ☐ Oral	Amount of feeding:
Duration:	For TF, Formula: Route: ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff / Corpak®
Diet:	
5. Pain	
Pain: ☐ No: Move to "Medications, IVs" questions ☐ Yes: Answer the other questions about pain	
Pain Location:	
Pain Medications (Route):	
Initial pain rating (out of 10):	Pain Relief: ☐ Yes ☐ No Rating (out of 10):
6. Medications, IVs	
Medications, IVs:	
Invasive Lines:	
IV Medications:	
Dialysis: ☐ Yes ☐ No ☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal Frequency: Access:	

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Member Name:
Contract Number:

7. Skin
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: ☐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 Would 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 #9 on the last page of this form. *
8. Rehabilitation Therapy
Physical Therapy Bed Mobility: Transfers: Ambulation: Distance: Assistive Devices:
Occupational Therapy Feeding: Bathing (Upper Body): Dressing (Upper Body): Bathing (Lower Body): Dressing (Lower Body): Grooming: Toileting / Hygiene: ADL/Toilet Transfers:
Speech / Language Therapy ☐Dysphagia Evaluation ☐Modified barium swallow results: Risks / Recommendations:

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9. 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:
10. Additional Comments