LTACH Assessment Form

Complete this form and fax it to **877-218-9089**. 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.

_____ /_____ /________ ☐ Precertification ☐ Recertification
Today's Date

Section 1 – Member and LTACH Information

Member Name ______________________ Age ________ Date of Birth _____ /_____ /________

Contract Number ______________________ Phone Number (_____) _____ - ________

Resides: ☐ Alone ☐ With spouse ☐ With other

Support: ☐ Spouse ☐ Children ☐ Family/Friend ☐ Other

Home description (steps to enter, levels, bed/bath location, etc.):

Comments:

Acute Hospital Name ______________________ Acute Hospital Admission Date _____ /_____ /________ Hospital Phone Number (_____) _____ - ________

Hospital Contact Name ______________________

LTACH Name & NPI ______________________ LTACH Admitting Physician & NPI ______________________

LTACH Contact Name ______________________ LTACH Admission Date _____ /_____ /________ LTACH Phone Number (_____) _____ - ________

LTACH Reviewer for Updates ______________________ LTACH Reviewer Phone Number (_____) _____ - ________ LTACH Reviewer Fax Number (_____) _____ - ________

LTACH Admitting Diagnosis

Acute diagnosis with synopsis of acute hospital admission (including pertinent radiology results) and ICD-10 code:

Past medical history:

Surgeries/procedures (with dates): ______________________

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Please continue on the next page.

Section 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: ______

Section 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:

______

______

______

______

Section 4 – Diet

Type: ☐ NPO ☐ TF ☐ TPN ☐ Oral

Amount of feeding: ______

Duration: ______

For TF, Formula:
Route: ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff/Corpak®

Diet:

______

______

______

______

Please continue on the next page.

Section 5 – Pain

Pain: ☐ Yes ☐ No
If Yes, answer the following questions. If No, proceed to Section 6.

Initial pain rating (out of 10): ______

Pain relief: ☐ Yes ☐ No

Rating (out of 10): ______

Pain location:

Pain medications (route):

Section 6 – Medications and IVs

Medications, IVs:

Invasive lines:

IV medications:

Dialysis: ☐ Yes ☐ No

☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal

Frequency:

Access:

Section 7 – Skin

Skin intact? ☐ Yes ☐ No
If No, answer the remaining questions in this section.

Wound/incision #1:

Stage: ☐ I ☐ II ☐ III ☐ IV ☐ Not able to be staged

Size (L x W x D in cm): ______

Description:

Treatment: ______

Frequency: ______

Specialty bed? ☐ Yes ☐ No

Specialty bed type: ______

Wound vac? ☐ Yes ☐ No

Provider name: ______

Wound/incision #2:

Stage: ☐ I ☐ II ☐ III ☐ IV ☐ Not able to be staged

Size (L x W x D in cm): ______

Description:

Treatment: ______

Frequency: ______

Wound debridement? ☐ Yes ☐ No ____ / ____ / ____
Date

HBO?: ☐ Yes ☐ No

Provider name: ______

To add more clinical information, use the space provided in Section 9 on the last page of this form.

Please continue on the next page.

Section 8 – Rehabilitation Therapy

Physical Therapy

Bed mobility: ____________________

Transfers: ____________________

Ambulation: ____________________

Distance: ____________________

Assistive devices: ____________________

Speech/Language Therapy

☐ Dysphagia evaluation

☐ Modified barium swallow results:

____

Risks/Recommendations:

____

____

Occupational Therapy

Feeding: ____________________

Bathing (upper body): ____________________

Dressing (upper body): ____________________

Bathing (lower body): ____________________

Dressing (lower body): ____________________

Grooming: ____________________

Toileting/hygeine: ____________________

ADL/toilet transfers: ____________________

Section 9 – Discharge (D/C) Plans

_____ /_____ /________
D/C 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

Section 10 – Additional Notes

____

____

____

____

____

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____

____