

Long Term Acute Care Hospital Continued Stay Request Form

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

Date of Request:	<input type="checkbox"/> Standard <input type="checkbox"/> Retro	Urgent Request <i>Note: Expedited organization determinations (urgent requests), can only be requested by the Member (or their representative) or a Physician. See CMS Chapter 13 regulation: 50.1</i>
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Member Information:		
Member Name:	Member ID:	Date of Birth:

Requesting LTACH Facility Information		
Facility Name:	Facility TIN:	
NPI:	Attending Physician:	Is there a medical power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Phone:	Attending Physician NPI:	
Fax:		Name and relationship to patient:
LTACH Facility Contact Name:	LTACH admission date:	
LTACH Facility Contact Phone:	Anticipated LTACH Discharge date:	<i>If available, please attach POA/AOR with request</i>
LTACH Facility Contact Fax:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> N	Does the patient have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

INSTRUCTIONS

Submission MUST include the following as part of your referral package:

- All pages of this referral form (fully completed – include comments).
- LTACH H & P
- Last 2-3 days of physician progress notes.
- Last 2-3 days of nursing notes.
- Specialty consultations.
- Complete list of all current medications including IV antibiotic end date(s).
- Diagnostics (CT scans / X-ray reports) and most recent lab work.
- Ventilator Weaning Requests – ventilator flow sheets with the last four days of weaning trials.
- Most recent wound care documentation.

MEDICAL AND PHYSICAL STATUS

Admitting ICD-10 Code(s)			
1 (Primary)	2	3	4

Select Clinical Category:
<input type="checkbox"/> Ventilator Management <input type="checkbox"/> Respiratory Complex
<input type="checkbox"/> Cardiac Complex <input type="checkbox"/> Medically Complex
<input type="checkbox"/> Wound Complex

Reason For Continued LTACH Stay:
Past Medical History/Other Medical Conditions:

Discharge Planning (general):			
Previous living situation		Planned d/c living situation	
Home alone	Supportive Housing	Home alone	Supportive Housing
Home with spouse	Homeless	Home with spouse	Homeless
Home with family/caregiver	Unknown	Home with family/caregiver	Unknown
Long Term Care	Other (describe):	Long Term Care	Other (describe):
For discharge plans to return home:		For discharge plans to long term care or supportive housing:	
Is there a caregiver identified and able to assist the patient? [IF YES] [IF YES] Caregiver ability to provide care: [IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? [IF YES] Has caregiver training been completed? Home Living Environment: # of steps to enter: _____ Rails: Is there a ramp to enter? Bed 1st Floor Bath 1st Floor Is there ability for first floor setup? If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? If yes, Name of Company:		Has a facility been chosen? [IF YES] Name of facility: Has an application been completed? Is it anticipated that a bed/room be available for the patient? Is it anticipated that the facility will be able to provide the level of care needed at discharge? Does patient require an application for Medicaid? Discharge Plan Comment:	
Future surgery scheduled <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify type of surgery, date, surgeon's name, and location		
Any Medical Changes since date of last review:			

Planned Treatment Interventions

Most recent vitals: Temp:	Pulse:	RR:	BP:	O2 sat:
Weight:	Height:			
Neurologically stable last 24 hours?	Yes	No		
Current: Alert & Oriented x	Ability to follow commands:			

Current Level of Function:

Ambulation:	# Feet
Wheelchair Mobility:	
Transfers:	
Grooming/Hygiene:	
Bathing:	
Dressing:	
Toileting:	
DME needed: wheelchair walker cane bedside commode shower chair Hoyer lift brace other	
Additional Info:	

Respiratory

Oximetry:	Vent: Yes No	Venti Mask/liters:	NC/liters:
Mode:	Rate:	TV:	Peep:
FiO2:			
Dates and progress of Vent Weaning Attempts:			
<input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP		How long:	Oxygen saturation response:
Tracheostomy: Yes No		Date Inserted:	Decannulation trial:
Cardiac Rhythm/telemetry: Yes No		NYHA class <IV? Yes No N/A	Continuous Sedation/Paralytic Infusions? Yes No N/A
Other lines: chest tubs, drainage device, etc.:			
Pain Management and Pain Control:			
Additional Information:			

IV Therapy

IV Medication	Dose	Type of Line (central/picc/etc)	Frequency	Start Date	End Date

Dialysis: Yes No	Acute Chronic HD	Peritoneal
	Frequency:	Access:
Additional Information:		

Nutrition

Diet Type	NPO	TF	TPN	Oral	
				Date Tube placed:	Date TPN started:
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		
Diet					
Additional Information					

Wound Care

<p>Skin Intact Yes</p> <p><i>No If not intact, answer the remaining questions about the member's wounds/incisions.</i></p> <p>Specialty Bed Yes Type:</p> <p>No</p>	
Wound/Incision #1:	Wound/Incision #2:
<p>Location:</p> <p>Stage:</p> <p>Size: LxWxD (cm) _____ x _____ x _____</p> <p>Description:</p> <p>Treatment/Dressings:</p> <p>Wound Debridement: Yes No Date:</p> <p>Frequency:</p> <p>Wound Vac: Yes No</p>	<p>Location:</p> <p>Stage:</p> <p>Size: LxWxD (cm) _____ x _____ x _____</p> <p>Description:</p> <p>Treatment/Dressings:</p> <p>Wound Debridement: Yes No Date:</p> <p>Frequency:</p> <p>Wound Vac: Yes No</p>
Wound/Incision #3:	Wound/Incision #4:
<p>Location:</p> <p>Stage:</p> <p>Size: LxWxD (cm) _____ x _____ x _____</p> <p>Description:</p> <p>Treatment/Dressings:</p> <p>Wound Debridement: Yes No Date:</p> <p>Frequency:</p> <p>Wound Vac: Yes No</p>	<p>Location:</p> <p>Stage:</p> <p>Size: LxWxD (cm) _____ x _____ x _____</p> <p>Description:</p> <p>Treatment/Dressings:</p> <p>Wound Debridement: Yes No Date:</p> <p>Frequency:</p> <p>Wound Vac: Yes No</p>
Additional Information:	

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