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LONG TERM ACUTE CARE (LTAC) REQUEST

***PLEASE NOTE:**

- **ALL LTAC PATIENTS REQUIRE AT LEAST DAILY MEDICAL PRACTITIONER ASSESSMENT/INTERVENTION.**
- **VENT PATIENTS REQUIRE RESPIRATORY THERAPY AT LEAST 3X/24HRS *AND* AT LEAST 6.5HRS OF NURSING SERVICES DAILY.**
- **MEDICALLY COMPLEX PATIENTS REQUIRE AT LEAST 6.5HRS OF NURSING SERVICES DAILY.**

*** If these requirements are not met, please consider alternative level of care.

Fax: 1-833-581-1863

Please complete all sections of the form as applicable

- Part One – Reason for LTAC Stay
- Part Two – Prior Level of Function
- Part Three – Clinical Review
- Part Four – Respiratory Therapy
- Part Five – Rehab Therapy
- Part Six – Discharge Planning

ADMISSION INFORMATION	ANSWER
Admission Date to LTAC Facility	
Primary Diagnosis/Condition	
Active Comorbid Conditions (ex. COPD, uncontrolled DM, heart failure, new functional impairment, etc.)	

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PART ONE – REASON FOR LTAC STAY

Reason for Stay	Answer
Medically Complex, Vent Management/Weaning, Wound/Skin	

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PART TWO – PRIOR LEVEL OF FUNCTION

Category	Response
Level of assistance prior to illness for ADLs/IADLs	O Independent, O Modified Independence, O Supervision, O Contact Guard Assist, O Minimal Assistance, O Moderate Assistance, O Maximum Assistance, O Total Assistance/Dependent
Does the member ambulate	O Yes O No
Does the member have gait limitations: (If yes specify limitation and assistance required.)	O Yes O No Specify: ___________________________
Wheelchair mobility: yes/no	O Yes O No
Does member have DME at home? If yes, specify	O Yes O No Specify: _____________________________
Community or other resources already in place: (Meals on Wheels, HHC, caregivers, etc.)	O Meals on Wheels OHHC O Caregivers O Other: _________________
Baseline mental status:	
Does the member have any cognitive issues such as communication difficulty, memory deficits, perception or processing deficits?	O Yes O No Specify: _____________________________
Does the member have any physical limitations such as wound location unreachable, contractures, obesity, motor strength, comorbidity such as blindness or paralysis?	O Yes O No Specify: _____________________________
Is the home environment not conducive to care such as no running water, no phone, no temperature control, no elevator, no access to home care agency or outpatient services, any physical or emotional abuse at home:	O Yes O No Specify: _____________________________
Home oxygen: (yes/no) if yes, specify	O Yes O No Specify: _____________________________

Home set up	Responses
# steps to enter home:	
Stair Rails: (yes/no)	O Yes O No
Bed on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Bath on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Availability for first floor setup: (yes/no)	O Yes O No
Who does the member live with currently: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	O Home Alone O Personal Care Home O Caregiver/family/significant Other O Assisted Living Facility O Long Term Residential Care O Other: ________________

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PART THREE - CLINICAL REVIEW

Clinical Reviews must be submitted within 48 hours of requested Admission Date.
Continued Stay Requests must be requested within 24 hours from the last covered day.

NURSING

Category	Responses
Vitals:	
Recent Imaging Stable? If NO, please specify	O Yes O No Specify: ______________________________
Current Mental Status: Able to follow commands: (yes/no)	O Yes O No
Abnormal Labs (if being monitored or treated):	O Yes O No Specify: ______________________________
Continued IV medications: frequency, tentative stop dates** **note: vent weaning patients must be off continuous paralytic infusions**	Frequency: __________________________ Tentative Stop Dates: __________________
Hemodialysis: if yes, frequency	O Yes O No Frequency: ____________________________
Oral diet: (yes/no) if yes, type	O Yes O No Specify: ______________________________
NG/PEG: (include date placed, type of feeds, rate, goal rate)	
TPN: (yes/no) if yes rate	O Yes O No Rate: ______________________________
Wounds/treatment: (include stage, tx, measurements, frequency dressing, appointment with wound specialist)	Stage: __________________________ TX Measurements: ___________________ Frequency Dressing: __________________ Appointment with Wound Specialist: ____________________________________

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PART FOUR - RESPIRATORY THERAPY

Clinical Reviews must be submitted within 48 hours of requested Admission Date.
Continued Stay Requests must be requested within 24 hours from the last covered day.

Category	Response
Vent Dependent at least 6H and active weaning planned- if yes, please provide vent settings (if trach present include size and placement date)	O Yes O No Specify: ______________________________ Vent Settings: __________________________ Size: _________________________________ Placement Date: ________________________
Weaning potential: spontaneous breathing trial started, if yes, please provide date and tolerance	O Yes O No Date: ____________________________ Tolerance: ________________________
Chest PT: if yes, please include frequency	O Yes O No Frequency: ___________________________
Breathing treatments/nebs- type and frequency	O Yes O No Type: _______________________________ Frequency: ___________________________

PART FIVE - REHAB THERAPY

Category	Response
Therapy: PT/OT, if YES include frequency.	O Yes O No Specify: ______________________________ Frequency: ____________________________
Speech Therapy: If YES, include treatment plan and frequency	O Yes O No Frequency: ____________________________ Treatment Plan: ____
Specialty equipment: ex. Dolphin bed, bariatric equipment	

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PART SIX - DISCHARGE PLANNING

Category	Response
Anticipated length of stay	
Discharge plan: include tentative discharge disposition and discharge date	
Additional information and/or Discharge Barriers	