

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	

PART TWO – PRIOR LEVEL OF FUNCTION

Category	Response
Level of assistance prior to illness for ADLs/IADLs	<input type="radio"/> Independent, <input type="radio"/> Modified Independence, <input type="radio"/> Supervision, <input type="radio"/> Contact Guard Assist, <input type="radio"/> Minimal Assistance, <input type="radio"/> Moderate Assistance, <input type="radio"/> Maximum Assistance, <input type="radio"/> Total Assistance/Dependent
Does the member ambulate	<input type="radio"/> Yes <input type="radio"/> No
Does the member have gait limitations: (If yes specify limitation and assistance required.)	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
Wheelchair mobility: yes/no	<input type="radio"/> Yes <input type="radio"/> No
Does member have DME at home? If yes, specify	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
Community or other resources already in place: (Meals on Wheels, HHC, caregivers, etc.)	<input type="radio"/> Meals on Wheels <input type="radio"/> HHC <input type="radio"/> Caregivers <input type="radio"/> Other: _____
Baseline mental status:	
Does the member have any cognitive issues such as communication difficulty, memory deficits, perception or processing deficits?	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
Does the member have any physical limitations such as wound location unreachable, contractures, obesity, motor strength, comorbidity such as blindness or paralysis?	<input type="radio"/> Yes <input type="radio"/> 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:	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
Home oxygen: (yes/no) if yes, specify	<input type="radio"/> Yes <input type="radio"/> No Specify: _____

Home set up	Responses
# steps to enter home:	
Stair Rails: (yes/no)	<input type="radio"/> Yes <input type="radio"/> No
Bed on first or second floor: (1st floor/2nd floor)	<input type="radio"/> 1 st <input type="radio"/> 2 nd
Bath on first or second floor: (1st floor/2nd floor)	<input type="radio"/> 1 st <input type="radio"/> 2 nd
Availability for first floor setup: (yes/no)	<input type="radio"/> Yes <input type="radio"/> 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)	<input type="radio"/> Home Alone <input type="radio"/> Personal Care Home <input type="radio"/> Caregiver/family/significant Other <input type="radio"/> Assisted Living Facility <input type="radio"/> Long Term Residential Care <input type="radio"/> Other: _____

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	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
Current Mental Status: Able to follow commands: (yes/no)	<input type="radio"/> Yes <input type="radio"/> No
Abnormal Labs (if being monitored or treated):	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> No Frequency: _____
Oral diet: (yes/no) if yes, type	<input type="radio"/> Yes <input type="radio"/> No Specify: _____
NG/PEG: (include date placed, type of feeds, rate, goal rate)	
TPN: (yes/no) if yes rate	<input type="radio"/> Yes <input type="radio"/> No Rate: _____
Wounds/treatment: (include stage, tx, measurements, frequency dressing, appointment with wound specialist)	Stage: _____ TX Measurements: _____ Frequency Dressing: _____ Appointment with Wound Specialist: _____

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)	<input type="radio"/> Yes <input type="radio"/> No Specify: _____ Vent Settings: _____ Size: _____ Placement Date: _____
Weaning potential: spontaneous breathing trial started, if yes, please provide date and tolerance	<input type="radio"/> Yes <input type="radio"/> No Date: _____ Tolerance: _____
Chest PT: if yes, please include frequency	<input type="radio"/> Yes <input type="radio"/> No Frequency: _____
Breathing treatments/nebs- type and frequency	<input type="radio"/> Yes <input type="radio"/> No Type: _____ Frequency: _____

PART FIVE - REHAB THERAPY

Category	Response
Therapy: PT/OT, if YES include frequency.	<input type="radio"/> Yes <input type="radio"/> No Specify: _____ Frequency: _____
Speech Therapy: If YES, include treatment plan and frequency	<input type="radio"/> Yes <input type="radio"/> No Frequency: _____ Treatment Plan: _____
Specialty equipment: ex. Dolphin bed, bariatric equipment	

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	