BlueCross BlueShield of Alabama

LTAC PRE-ADMISSION EVALUATION FORM

Please fax this form to the patient's Care Coordinator at:
BLUE CROSS and BLUE SHIELD OF ALABAMA

For Care Coordinator fax/contact information please call 800-821-7231

Please print legibly

Facility Name		In Blue Cross Network Y N
Facility Address (city, state, zip code)		Phone Number
Patient Name	Date of Birth	Contract Number
Patient Address (city, state, zip code)	Phone Number	Other Insurance Coverage Circle: MC VA Commercial Contract #
Caregiver contact Name	C/G Home Phone Number	C/G Cell/Alternate Number
Referring Physician	Referring Physician Phone Number	
Referring Physician Address (city, state, zip code)		
Referring Hospital Name	Phone Number	Admit Date
Hospital Contact Name and Number		
Referring Hospital Address		
Primary Diagnosis for Admission to LTAC		
Secondary Diagnosis	Anticipated LOS	
LTAC Referral Discussed With Patient/Caregiver Y N		

Planned Treatment Intervention (Please document specific physician's orders)

Ventilator Weaning
Oxygen
IV Therapy
Medications
Wound Care
Nutrition
Rehab Therapy
Specialty Needs (DME, HD, Telemetry, etc.)

Discharge Plan (From LTAC)

Discharge Destination: Home Home Health Assisted Living Facility Inpatient Rehab SNF LTC Hospice

Prior Living Arrangements:

Home DME: Wheelchair Hospital Bed Assistive Device Other_____

House /Apartment/Other: Levels 1-2-3 #Steps Entrance _____ Inside _____ Ramp_____

Facility_____

InterQual® Admission Criteria: Circle applicable subset

Medically Complex **Vent Weaning**
Respiratory Complex **Infectious Disease**
Wound/Skin **CVPV**

History of Current Hospitalization (Please Fax H & P)

Primary Acute Diagnosis:

Surgery This Admission:

Prior Level of Function:

Current Level of Function:

Respiratory

Oxygen Home O2

Nasal Cannula_____liters/min

Mask @_____percent

Ventilator Bipap

Ventilator settings: MODE RATE TV PEEP FiO2 PS

Tolerating Weaning Attempts Y/N_____ Number Attempts_____

Current ABGs Date_____ pH_____ PCO2_____HCO3_____PO2_____ SaO2_____

Current CXR Y/N Date_____ Results:

Intubated ET tube Tracheostomy Date

Other Lines: Chest tube, Drainage Device, Dialysis Catheter

CVPV Telemetry

Neurological

Musculoskeletal

GI

Nutrition Albumin: HT/WT: