



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
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Facility Address (city, state, zip code)	Phone Number
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Patient Name	Date of Birth	Contract Number
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Patient Address (city, state, zip code)	Phone Number	Other Insurance Coverage Circle: MC VA Commercial Contract #
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Caregiver contact Name	C/G Home Phone Number	C/G Cell/Alternate Number
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Referring Physician	Referring Physician Phone Number
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Referring Physician Address (city, state, zip code)

Referring Hospital Name	Phone Number	Admit Date
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Hospital Contact Name and Number

Referring Hospital Address

Primary Diagnosis for Admission to LTAC

Secondary Diagnosis	Anticipated LOS
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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:**CONFIDENTIALITY NOTICE:**

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