BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

LONG TERM ACUTE CARE PRE-ADMISSION EVALUATION

Please fax this form to the Patient's Care Coordinator at **BLUE CROSS AND BLUE SHIELD.**
For precertification, fax form to 1-205-733-7020 or call 1-855-288-8357.

Please Print Legibly

Facility Name		In Blue Cross Network ☐ YES ☐ NO
Facility Address Address (City, State, Zip)		Phone Number (☐☐☐)-☐☐☐-☐☐☐☐
Patient Name	Date of Birth ☐☐/☐☐/☐☐☐☐	Contact Number (☐☐☐)-☐☐☐-☐☐☐☐
Patient Address (City, State, ZIP)		Phone Number (☐☐☐)-☐☐☐-☐☐☐☐
Other Insurance Coverage ☐ Medicare ☐ Veterans Administration ☐ Commercial		Contract Number
Caregiver Name	Caregiver Home Phone Number (☐☐☐)-☐☐☐-☐☐☐☐	Caregiver Cell Phone/Alternate Number (☐☐☐)-☐☐☐-☐☐☐☐
Referring Physician		Referring Physican Phone (☐☐☐)-☐☐☐-☐☐☐☐
Referring Physician Address (City, State, ZIP)		
Referring Hospital Name	Hospital Phone Number (☐☐☐)-☐☐☐-☐☐☐☐	Admit Date ☐☐/☐☐/☐☐☐☐
Hospital Contact Name		Hospital Contact Number (☐☐☐)-☐☐☐-☐☐☐☐
Referring Hospital Address (City, State, ZIP)		
Primary Diagnosis for Admission to LTAC		
Secondary Diagnosis	Anticipated LOS	
LTAC Referral Discussed with Patient/Caregiver? ☐ YES ☐ NO		

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 ☐ Hosptial Bed ☐ Assistive Device ☐ Other _____

House/Apartment/Other: Levels ☐ 1 ☐ 2 ☐ 3 | Number of Steps Entrance _____ Number of Steps Inside _____ Ramps _____

Facility

InterQual® Admission Criteria: Check applicable subset

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

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 ☐ YES ☐ NO Number of Attempts _____

Current ABGs _____ pH _____ PCO2 _____ HCO3 _____ PO2 _____ SaO2 _____

Current CXR ☐ YES ☐ NO Date _____ Results: _____

☐ Intubated ☐ ET Tube ☐ Tracheostomy Date _____

Other Lines: ☐ Chest Tube ☐ Drainage Device ☐ Dialysis Catheter

☐ CVPV | ☐ Telemetry

Neurological

Musculoskeletal

GI

Nutrition	Albumin:	HT/WT: