



LONG TERM ACUTE CARE PRE-ADMISSION EVALUATION

Please fax this form to the Patient's Care Coordinator at **CREDENCE**.
For precertification, fax form to 833-719-1602 or call 833-663-8703.

Please Print Legibly

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

CONFIDENTIALITY NOTICE:

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