LTAC CONTINUED STAY AUTHORIZATION

Inpatient Rehab/SNF Team **Phone: (313) 664-8800** **Fax: (313) 664-5820**

Instructions: Complete form and fax to the number above. We follow InterQual criteria for review.

Member name: ____________________ **HAP ID#:** __________ **Today's date:** __________

Currently admitted to: ____________________ **Admission date:** __________

This progress report for dates of care (month/day/year) From: __________ **Through:** __________

Person completing form: ____________________ **Phone:** __________ **Fax:** __________

Care conference date: __________ **Family relationship assisting with plan of care:** __________

Physicians: Attending: ____________________ Consults: ____________________

DISCHARGE PLANNING UDPATE

Anticipated discharge date: __________ **Actual discharge date:** __________

To: ☐ Own residence ☐ Assisted living ☐ Sub acute rehab

Referrals to alternate level of care (ALOC) in process: ☐ Yes ☐ No **Date initiated** __________

Barriers to discharge:

Home evaluation date __________ **Findings**

Education completed by member/family: ____________________

Comments:

CLINICAL STATUS

Date: __________ **Temp:** __________ **Pulse:** __________ **RR:** __________ **BP Range:** __________

Cognitive status: ☐ Alert & orientated x 3 ☐ Alert & oriented x 2 ☐ Alert & orientated x 1 ☐ Not alert
☐ Lethargic ☐ Combative ☐ Responds to pain ☐ Comatose

Rancho level: __________ **Glasgow level:** __________ **Progressing?** ☐ Yes ☐ No

Behavioral symptoms:
(new onset or increasing)

Restraints: ☐ Yes ☐ No **Type:** ____________________

Restraints discontinued on: ____________________

RESPIRATORY STATUS

Vent settings: ☐ AC ☐ IMV ☐ CPAP **TV** __________ **FIO2%** __________ **PS** __________ **Peep** __________

O2 Device: ☐ Vent ☐ T-Bar ☐ Trach ☐ OT tube ☐ Collar ☐ Cannula ☐ Mask

BiPap setting _____ / _____ **FIO2%** __________ **Date Vented** __________ **Date Trached** __________

Trach size/Type ____________________

Weaning: ☐ Yes ☐ No **Time/Method** ____________________

Reason not weaning ____________________

Suction frequency __________ **Type/color of secretions** __________ **Pulse ox range** __________

Last ABG results ____________________

Last CXR results ____________________

GI/GU STATUS/NUTRITION

Dialysis: ☐ (M, W, F) ☐ (T, TH, S) ☐ Hemodialysis ☐ CAPD ☐ AV Fistula site ☐ Quinton site

Feeding: ☐ PO ☐ NPO ☐ PEG ☐ PEJ ☐ TPN ☐ LIPIDS ☐ Small Bore/DOBHOFF ☐ NGT

Diet/Feedings/Supplements

Weight (date/lbs) ______________________ ☐ Loss ☐ Gain

Albumin/Pre Albumin ______________________ **Date** ____________

Swallow study results

Bladder: ☐ Continent ☐ Incontinent ☐ Urostomy ☐ SP Cath ☐ Foley ☐ Condom Cath

Output: ______________________

Bowel: ☐ Continent ☐ Incontinent ☐ Ileostomy ☐ Colostomy ☐ Fecal Incontinence Device

Output: ______________________

Abnormal labs/dates

IV THERAPY

Type of line/location: ______________________

IV medication(s) – include dosage, frequency and duration

Isolation for: ______________________

Infectants: ______________________

SKIN

☐ **Intact** ☐ **Not intact** (if not intact, please provide **wound description** and **treatment** or attach wound care notes.

THERAPY

☐ **OT** ☐ **PT** ☐ **SLP** (If receiving therapy, **complete** OT/PT functional status and/or speech status forms and attach)

ADDITIONAL COMMENTS/ISSUES/CONCERNS:

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Nov. 2021