RECOVERY CARE FACILITY ADMISSION PRE-CERT

HIPAA Regulations prohibit sending more clinical information than is needed for pre-cert. Please send only the information required on this form, or the requested attachments – not the entire medical record.

********Please include with all requests: H&P, Pertinent Consults, Last MD Progress note available**********

Member Name: ___________________________________HAP ID#: ___________________Today's Date: ___________________

Discharging Facility:________________________________ Admission Date: _____________________
(Hospital)

Request Admission to: ____________________________ on ________________________
(Facility Name) (Date)

Person Completing this Form: ____________________________**Telephone or Pager:** __________________________________

Requested Service: ○ Skilled Nursing Placement ○ Sub Acute ○ Acute Rehab ○ LTAC

Estimated Length of Stay: ________

A. CURRENT CLINICAL STATUS:

Admission Diagnosis(es):____

Recent Surgical Procedure(s): ____Date: ___________________

Additional Diagnoses: ____

Pain Scale: (none) 0 - 10 (severe) ____ Location: ____________ **IV** Pain Medication:___________________________(**Frequency & dose**)

Cognitive Status: ____ Able ___Unable to follow **1 2** step directions (circle appropriate)

Physical Functional Level Prior to Admission: ____

Prior to Admission Member lived: Alone / With Family or Other Support **IN:** Own Residence / Assisted Living / Nursing Home

Discharge Plan after Skilled/IPR/LTAC Placement : ____

(Must complete discharge plan or anticipated discharge plan)

B. SKILLED SERVICES REQUIRED: Please check off, fill in and circle all applicable items:

☐ PEG tube feedings**:** ____ **(Formula, Rate and # of Hours infusion)**

☐ IV Antibiotics/TPN**:** ____ **(Dose, Frequency, Type of Line, Duration)**

☐ Stage III or IV Wound / Stasis Wound / Open Surgical Wound: (If > 1 wound please include wound consult and current wound note

Site: ____________________________________ **Size in Centimeters:** ____**length** _____**width** _____**depth** **Stage/Surgical:** ______

Treatment and frequency: ____

☐ Ventilator Care**:** ____ **(Settings) Include Last two to three Respiratory Care Notes.**

1) Ventilator Care: include 3 days respiratory notes:

a) Weaning trials_____frequency_____VT___02____PEEP____CPAP trials____________________________

b) Trach Care: ______Frequency of suction____02 requirements______%Devices: MASK / SHIELD / COLLAR

☐ **Therapies**: Please attach **Therapy evaluations and current therapy notes (done within 24hrs for IPR request and within 48hrs for Skilled :**

Physical Therapy, Occupational Therapy and Speech Therapy

Check the number of hours of daily therapy patient can tolerate today: 3hrs _____ 2hrs_____ 1hr______

☐ Other: _________________________ (Specify skilled service required and fax attach note specific to the request)

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A verbal authorization will be given for transfer of the member. It is the admitting facility's responsibility to notify HAP at (313-664-8833 or 800-288-5959) within 24 hours of the member's arrival.