

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

| | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--|
| 1. PATIENT'S LAST NAME | | FIRST | MIDDLE | 2. BIRTHDATE (M/D/Y) | | 3. SEX | 4. ADMISSION DATE (CURRENT LOCATION) | |
| 5. COUNTY AND MEDICAID NUMBER | | | 6. FACILITY ADDRESS | | | 7. PROVIDER NUMBER | | |
| 8. ATTENDING PHYSICIAN NAME AND ADDRESS | | | | | 9. RELATIVE NAME AND ADDRESS | | | |
| 10. CURRENT LEVEL OF CARE | | 11. RECOMMENDED LEVEL OF CARE | | 12. PRIOR APPROVAL NUMBER | | 14. DISCHARGE PLAN | | |
| <input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> SNF <input type="checkbox"/> OTHER <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL | | <input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> SNF <input type="checkbox"/> OTHER <input type="checkbox"/> ICF | | 13. DATE APPROVED/DENIED | | <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER | | |

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

| | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

16. PATIENT INFORMATION

| | | | |
|---------------------------------|-------------------------------|-------------------------------|-------------------------|
| DISORIENTED | AMBULATORY STATUS | BLADDER | BOWEL |
| CONSTANTLY | AMBULATORY | CONTINENT | CONTINENT |
| INTERMITTENTLY | SEMI-AMBULATORY | INCONTINENT | INCONTINENT |
| INAPPROPRIATE BEHAVIOR | NON-AMBULATORY | INDWELLING CATHETER | COLOSTOMY |
| WANDERER | FUNCTIONAL LIMITATIONS | EXTERNAL CATHETER | RESPIRATION |
| VERBALLY ABUSIVE | SIGHT | COMMUNICATION OF NEEDS | NORMAL |
| INJURIOUS TO SELF | HEARING | VERBALLY | TRACHEOSTOMY |
| INJURIOUS TO OTHERS | SPEECH | NON-VERBALLY | OTHER: |
| INJURIOUS TO PROPERTY | CONTRACTURES | DOES NOT COMMUNICATE | O2 PRN CONT. |
| OTHER: | ACTIVITIES/SOCIAL | SKIN | NUTRITION STATUS |
| PERSONAL CARE ASSISTANCE | PASSIVE | NORMAL | DIET |
| BATHING | ACTIVE | OTHER: | SUPPLEMENTAL |
| FEEDING | GROUP PARTICIPATION | DECUBITI – DESCRIBE: | SPOON |
| DRESSING | RE-SOCIALIZATION | | PARENTERAL |
| TOTAL CARE | FAMILY SUPPORTIVE | | NASOGASTRIC |
| PHYSICIAN VISITS | NEUROLOGICAL | | GASTROSTOMY |
| 30 DAYS | CONVULSIONS/SEIZURES | | INTAKE AND OUTPUT |
| 60 DAYS | GRAND MAL | DRESSINGS: | FORCE FLUIDS |
| OVER 180 DAYS | PETIT MAL | | WEIGHT |
| | FREQUENCY | | HEIGHT |
| 17. SPECIAL CARE FACTORS | FREQUENCY | SPECIAL CARE FACTORS | FREQUENCY |
| BLOOD PRESSURE | | BOWEL AND BLADDER PROGRAM | |
| DIABETIC URINE TESTING | | RESTORATIVE FEEDING PROGRAM | |
| PT (BY LICENSED PT) | | SPEECH THERAPY | |
| RANGE OF MOTION EXERCISES | | RESTRAINTS | |

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

| | |
|----|-----|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE

22. DATE