myNEXUS

LONG TERM ACUTE CARE HOSPITAL CONTINUED STAY REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

FOR FASTER AUTHORIZATION, PLEASE VISIT:
https://portal.mynexuscare.com

Date of Request:	☐Standard ☐Retro	☐ Urgent Request *Note: Expedited organization determinations (urgent requests), can only be requested by the Member (or their representative) or a Physician. See CMS Chapter 13 regulation: 50.1*

Member Information:

Member Name:	Member ID:	Date of Birth:

Requesting LTACH Facility Information		
Facility Name:		
NPI:	Attending Physician:	Is there a medical power of attorney?
Phone:	Attending Physician NPI:	◻ Yes ◻ No ◻ Unknown
Fax:		Name and relationship to patient:
LTACH Facility Contact Name:	LTACH admission date:	
LTACH Facility Contact Phone:	Anticipated LTACH Discharge date:	*If available, please attach POA/AOR with request*
LTACH Facility Contact Fax:	Is member currently in your facility? ☐ Y ☐ N	Does the patient have an advanced directive? ◻ Yes ◻ No ◻ Unknown

INSTRUCTIONS

Submission MUST include the following as part of your referral package:

◻ All pages of this referral form (fully completed – include comments).
◻ LTACH H & P
◻ Last 2-3 days of physician progress notes.
◻ Last 2-3 days of nursing notes.
◻ Specialty consultations.
◻ Complete list of all current medications including IV antibiotic end date(s).
◻ Diagnostics (CT scans / X-ray reports) and most recent lab work.
◻ Ventilator Weaning Requests – ventilator flow sheets with the last four days of weaning trials.
◻ Most recent wound care documentation.

MEDICAL AND PHYSICAL STATUS

Admitting ICD-10 Code(s)			
1 (Primary)	2	3	4

Select Clinical Category:	
☐ Ventilator Management	☐ Respiratory Complex
☐ Cardiac Complex	☐ Medically Complex
☐ Wound Complex	

Reason For Continued LTACH Stay:
Past Medical History/Other Medical Conditions:

Discharge Planning (general):	
Previous living situation □ Home alone □ Home with spouse □ Home with family/caregivers □Long Term Care □ Supportive housing □ Homeless □ Unknown □ Other (comment}: **Planned d/c living situation** □ Home alone □ Home with spouse □ Home with Family/Caregivers □Long Term Care □ Supportive housing □ Unknown □ Other (comment}:	
For discharge plans to return home:	For discharge plans to long term care or supportive housing:
Is there a caregiver identified and able to assist the patient? □Yes □No □Unknown **[IF YES]** □ 24hrs □ Daytime only □ Evening Only **[IF YES] Caregiver ability to provide care:** □ Grocery Shopping □ Meal Prep □ Non-Transfer Assistance (feeding/dressing) □ Transfer Assistance (in/out of bed, toileting) □ Full ADL Assistance **[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely?** □Yes □No □ Unknown **[IF YES] Has caregiver training been completed?** □Yes □No □ Unknown Home Living Environment: **# of steps to enter: ____________Rails:** □Yes □No □ Unknown **Is there a ramp to enter?** □Yes □No □ Unknown **Bed 1st Floor** □Yes □No □ Unknown **Bath 1st Floor** □Yes □No □ Unknown **Is there ability for first floor setup?** □Yes □No □ Unknown **If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient?** □Yes □No □ Unknown **If yes, Name of Company:**	**Has a facility been chosen?** □ Yes □ No □ LTC resident □ Unknown **[IF YES] Name of facility:** **Has an application been completed?** □ Yes □ No □ LTC resident □ Unknown **Is it anticipated that a bed/room be available for the patient?** □ Yes □ No □ Unknown **Is it anticipated that the facility will be able to provide the level of care needed at discharge?** □ Yes □ No □ Unknown **Does patient require an application for Medicaid?** □ Yes □ No □ Unknown Discharge Plan Comment:

Future surgery scheduled ☐ Yes ☐ No	If yes, specify type of surgery, date, surgeon's name, and location
Any Medical Changes since date of last review:	

PLANNED TREATMENT INTERVENTIONS

Most recent vitals: Temp _________ Pulse ________ RR _________ BP __________ O2 sat _________ Weight ________ Height ________

Neurologically stable last 24 hours? ☐Yes ☐No

Mental Status: Baseline_________________________ **Current**: Alert & Oriented X ______ **Ability to follow commands:** __________________________
Comment:

Current Level of Function:

Date of Current Therapy Status:		
	Weight Bearing Status:	□ FWB □ WBAT □ PWB □ NWB □ Unknown
Ambulation:	# Feet:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Wheelchair Mobility (if applicable):		□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Bed Mobility:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Transfers:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
Stairs:	# Stairs:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Feeding:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Grooming/Hygiene:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Bathing:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Dressing:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	Toileting:	□ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown
	DME Needed:	□ wheelchair □walker □ cane □ bedside commode □ shower chair □ hoyer lift □ brace □ other Additional Info:

RESPIRATORY

Oximetry:	Vent ☐ Yes ☐ No	Venti mask/liters:	NC/Liters:	
Mode:	Rate:	TV:	PEEP:	FiO2:
Dates and Progress of Vent Weaning Attempts				
☐ CPAP ☐ BiPAP	How long:	Oxygen saturation response:		
Tracheostomy: ☐ Yes ☐ No	Date Inserted:	Decannulation trial:		
CXR stable/improving? ☐Yes ☐No	☐ **Chest Physiotherapy.** Frequency: ____________________ ☐ **Nebulizer treatments:** Frequency: __________________ ☐ **Oxygen adjustments** (based on oximetry). Frequency: ______________________________ ☐ **Suctioning.** Frequency: ______________________________ Color: _______________ Amount: __________			
Cardiac rhythm/telemetry? ☐Yes ☐No	NYHA class <IV? ☐Yes ☐No ☐N/A	Continuous Sedation/Paralytic Infusions? ☐Yes ☐No ☐N/A		
Other Lines: chest tubes, drainage device, etc:				
Pain Management and Pain Control:				
Additional Information:				

IV THERAPY

IV Medication	Dose	Type of Line (central/picc/etc)	Frequency	Start Date	End Date

Dialysis: ☐Yes ☐No	☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal Frequency: Access:
Additional Information:	

NUTRITION

Diet Type	☐NPO ☐TF ☐TPN ☐Oral	
	Date Tube placed:	Date TPN started:
Amount of feeding	Duration	
For TF - Formula	Route ☐ NG ☐ PEG ☐J Tube☐ Dobhoff	
Diet		
Additional Information		

WOUND CARE

Skin Intact ☐Yes ☐No If not intact, answer the remaining questions about the member's wounds/incisions. **Specialty Bed** ☐Yes ☐No Type:		
Wound/Incision #1:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _______x ________x _______	
Description:		
Treatment/Dressings: Frequency: Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		
Wound/Incision #2:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _______x ________x _______	
Description:		
Treatment/Dressings: Frequency: Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		
Wound/Incision #3:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _______x ________x _______	
Description:		

Treatment/Dressings:	Frequency:
Wound Debridement ☐Yes ☐No	Date:
Wound Vac: ☐Yes ☐No	

Wound/Incision #4:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _______ x ________ x _______	
Description:		
Treatment/Dressings:	Frequency:	
Wound Debridement ☐Yes ☐No	Date:	
Wound Vac: ☐Yes ☐No		

Additional Information:

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