

**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:	<input type="checkbox"/> Standard <input type="checkbox"/> Retro	<input type="checkbox"/> Urgent Request <i>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</i>
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<b>Member Information:</b>		
Member Name:	Member ID:	Date of Birth:

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

<b>Admitting ICD-10 Code(s)</b>			
1 (Primary)	2	3	4

<b>Select Clinical Category:</b>
<input type="checkbox"/> Ventilator Management <input type="checkbox"/> Respiratory Complex <input type="checkbox"/> Cardiac Complex <input type="checkbox"/> Medically Complex <input type="checkbox"/> Wound Complex

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

<b>Future surgery scheduled</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify type of surgery, date, surgeon's name, and location
<b>Any Medical Changes since date of last review:</b>	

**PLANNED TREATMENT INTERVENTIONS**

<b>Most recent vitals:</b> Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____ Weight _____ Height _____  <b>Neurologically stable last 24 hours?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Mental Status:</b> Baseline _____ <b>Current:</b> Alert & Oriented X _____ <b>Ability to follow commands:</b> _____ <b>Comment:</b>
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**Current Level of Function:**

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

**RESPIRATORY**

Oximetry:	Vent <input type="checkbox"/> Yes <input type="checkbox"/> No	Venti mask/liters:	NC/Liters:	
Mode:	Rate:	TV:	PEEP:	FiO2:
<b>Dates and Progress of Vent Weaning Attempts</b>				
<input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP	How long:	Oxygen saturation response:		
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Inserted:	Decannulation trial:		
CXR stable/improving? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chest Physiotherapy. Frequency: _____ <input type="checkbox"/> Nebulizer treatments: Frequency: _____ <input type="checkbox"/> Oxygen adjustments (based on oximetry). Frequency: _____ <input type="checkbox"/> Suctioning. Frequency: _____ Color: _____ Amount: _____			
Cardiac rhythm/telemetry? <input type="checkbox"/> Yes <input type="checkbox"/> No	NYHA class <IV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Continuous Sedation/Paralytic Infusions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> HD <input type="checkbox"/> Peritoneal
	Frequency: _____ Access: _____
Additional Information:	

**NUTRITION**

Diet Type	<input type="checkbox"/> NPO <input type="checkbox"/> TF <input type="checkbox"/> TPN <input type="checkbox"/> Oral	
	Date Tube placed: _____	Date TPN started: _____
Amount of feeding	Duration	
For TF - Formula	Route <input type="checkbox"/> NG <input type="checkbox"/> PEG <input type="checkbox"/> J Tube <input type="checkbox"/> Dobhoff	
Diet		
Additional Information		

**WOUND CARE**

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

Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Wound/Incision #4:</b>		
Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not able to be staged	Size: L x W x D (cm) = _____x _____x _____	
Description:		
Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Additional Information:**

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