Print Form

Adult Care Home FL2 Form

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 NO. 13. DATE APPROVED/DENIED	14. DISCHARGE PLAN
☐ HOME ☐ SNF ☐ ICF ☐ HOSPITAL ☐ DOMICILIARY (REST HOME) ☐ OTHER _____	☐ HOME ☐ SNF ☐ ICF ☐ HOSPITAL ☐ DOMICILIARY (REST HOME) ☐ OTHER _____		☐ HOME ☐ SNF ☐ ICF ☐ HOSPITAL ☐ DOMICILIARY (REST HOME) ☐ 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	☐ COLOSCOPY
☐ 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 PROPERT	☐ CONTRACTURES	☐ DOES NOT COMMUNICATE	02 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	☐ DRESSINGS:	☐ PARENTERAL
☐ TOTAL CARE	☐ FAMILY SUPPORTIVE		☐ NASOGASTRIC
PHYSICIAN VISITS	**NEUROLOGICAL**		☐ GASTROSTOMY
☐ 30 DAYS	☐ CONVULSIONS/SEIZURES		☐ INTAKE AND OUTPUT
☐ 60 DAYS	☐ GRAND MAL		☐ 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 & STRENGTH, 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	DATE