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 PROPERTY	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