

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.		14. DISCHARGE PLAN	
<input type="checkbox"/> HOME <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER _____		<input type="checkbox"/> HOME <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER _____		13. DATE APPROVED/DENIED		<input type="checkbox"/> HOME <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL <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	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