# NC DMA Long Term Care FL2 Form

**Recipient Information** **DMA372-124**

1. Recipient Last Name:_____ 2. First Name:_____ 3. Recipient DOB:_____
4. Recipient ID #_____ 5. Recipient Gender:_____ 6. SSN: _____
7. Admission Date (current location): _____ 8. Facility Name: _____ 9. PASRR #: _____
10. Facility Address: _____ 11. Provider Number: _____
12. Attending Physician Name/Address: _____
13. Relative Name/Address: _____
14. Current Level of Care: ☐ Home ☐ SNF ☐ ICF ☐ Hospital ☐ Dom ☐ Other: _____
15. Requested Level of Care: ☐ Vent Care ☐ Nursing Facility ☐ NF Rehab ☐ Spec. Hosp Rehab ☐ Extended Care
☐ OOS NF ☐ OOS Vent ☐ CAP/CH SNF ☐ CAP/CH Hosp ☐ CAP/DA SNF ☐ CAP/DA ICF ☐ Other: _____
16. Discharge Plan: ☐ Home ☐ SNF ☐ ICF ☐ Dom ☐ Other: _____

**Diagnosis Information**

| | Admitting Diagnosis (code AND description) | Date of Onset | Primary (✓) |
|---|---|---|---|
| 1 | xxx | xxxx | x |
| 2 | xxx | xxxx | x |
| 3 | xxx | xxxx | x |
| 4 | xxx | xxxx | x |
| 5 | | | |

**Patient Information**

| Disoriented | Ambulatory Status | Bladder | Bowel |
|---|---|---|---|
| ☐ Constantly | ☐ Ambulatory | ☐ Continent | ☐ Continent |
| ☐ Intermittently | ☐ Semi-Ambulatory | ☐ Incontinent | ☐ Incontinent |
| **Inappropriate Behavior** | ☐ Non-Ambulatory | ☐ Indwelling Catheter | ☐ Colostomy |
| ☐ 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 | ☐ O2 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 | | ☐ Parenteral |
| ☐ Total Care | ☐ Family Supportive | | ☐ Nasogastric |
| **Physician Visits** | **Neurological** | | ☐ Gastronomy |
| ☐ 30 Days | ☐ Convulsions/Seizures | ☐ Dressings: | ☐ Intake and Output |
| ☐ 90 Days | ☐ Grand Mal | | ☐ Force Fluids |
| ☐ Over 180 Days | ☐ Petit Mal | | ☐ Weight |
| ☐ | ☐ Frequency | | ☐ Height |

| Special Care Factors | Frequency | Special Care Factors | Frequency |
|---|---|---|---|
| ☐ Blood Pressure | | ☐ Bowel & Bladder Program | |
| ☐ Diabetic Urine Testing | | ☐ Restorative Feeding Program | |
| ☐ PT (by licensed PT) | | ☐ Speech Therapy | |
| ☐ Range of Motion Exercises | | ☐ Restraints | |

**Medications – Name & Strength, Dosage and Route**

| | |
|---|---|
| **1.** | **7.** |
| **2.** | **8.** |
| **3.** | **9.** |
| **4.** | **10.** |
| **5.** | **11.** |
| **6.** | **12.** |

**X-ray and Laboratory Findings/Date:**

**Additional Information:**

_____ _____

**Physician's Signature** **Date**

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp