



INCOME SUPPORT DIVISION

Long Term Care Assessment Abstract

PLEASE REMEMBER THIS INFORMATION IS CONFIDENTIAL

DATE OF ASSESSMENT MM DD YY

ALL PREVIOUS

1. TYPE OF REVIEW (ONE) INITIAL _____ CONTINUED STAY _____ 2. DATE OF LAST ON-SITE REVIEW M M D D Y Y 3. DATE OF CURRENT ADMISSION M M D D Y Y

4. Facility _____ 5. Address _____

FACILITY NO _____

ADMIT ONLY

6. Patient _____

7. MEDICAID NUMBER _____ 8. DATE OF BIRTH M M D D Y Y

9. AGE _____ 10. SEX 1 (M) 2 (F) 11. SOURCE OF ADMISSION 1 HOSP 3 ICF 5 HOME 2 SNF 4 BOARD 6 OTHER 12. PREADMISSION REVIEW PERFORMED YES NO

ALL REVIEW

DIAGNOSES/PROBLEMS (one per line) IF RESIDENT HOSPITALIZED SINCE LAST CERTIFICATION, PLEASE ENTER REASON.

13. _____

14. _____

15. _____

16. _____

22. DAILY ACTIVITIES: (MUST CIRCLE ONE PER LINE)

NOTE: If resident is Semi-Comatose _____ or Comatose _____

Check (✓) and do NOT complete #22 thru #28

	INDEPENDENT	NEEDS HELP	REQUIRES TOTAL ASSISTANCE	BEDRIDDEN (✓ IF YES)
A. AMBULATION	1	2	3	-
B. BOWEL FUNCTION	1	2	3	-
C. TRANSFER	1	2	3	-
D. PERSONAL HYGIENE	1	2	3	-
E. EATING	1	2	3	-
F. BLADDER FUNCTION	1	2	3	-
	NONE	PHYSICAL OR CHEMICAL	COMBINED	
23. CONTROL/SAFETY	1	2	3	-
24. SENSORY CAPABILITIES:	NO IMPAIRMENT	IMPAIRMENT	TOTAL LOSS	PROSTHESIS (✓ IF YES)
A. SPEECH	1	2	3	-
B. HEARING	1	2	3	-
C. SIGHT	1	2	3	-
25. COMMUNICATION	NO PROBLEM	NON-VERBAL	DOES NOT COMMUNICATE	LANGUAGE BARRIER (✓ IF YES)
	1	2	3	
26. MENTAL	CLEAR	DISORIENTED	DISORIENTED	
	1	2	3	
27. BEHAVIOR	APPROPRIATE	INAPPROPRIATE PASSIVE	INAPPROPRIATE AGGRESSIVE	
	1	2	3	
28. SOCIABILITY	SOCIALIZES FREELY	OCCASIONALLY SOCIALIZES	AVOIDS OTHERS	
	1	2	3	
29. DECUBITI OR LESIONS	NO	YES	NEW	OLD
	1	2	3	4

21. NURSING SERVICES RELATED TO DIAGNOSES (Circle up to 6)

	FREQ.		FREQ.
1. STERILE DRESSING	_____	15. REHAB RESPIRATORY THER.	_____
2. SPEC. SKIN CARE	_____	16. MAINT SPEECH THERAPY	_____
3. SUCTIONING	_____	17. REHAB SPEECH THERAPY	_____
4. IV	_____	18. RETRAINING BOWEL/BLADDER	_____
5. TUBE FEEDING	_____	19. INJECTIONS	_____
6. OXYGEN	_____	20. BEHAVIOR OBSER.	_____
7. IRRIGATIONS	_____	21. ISOLATION	_____
8. INTAKE & OUTPUT	_____	22. SPEC. CATH.	_____
9. DECUBITUS CARE	_____	23. V/S EVAL.	_____
10. TRACH CARE	_____	24. C & A	_____
11. MED. REGULATION	_____	25. SPEC. OSTOMY CARE	_____
12. MAINT PHYSICAL THERAPY	_____		
13. REHAB PHYSICAL THERAPY	_____		
14. MAINT RESPIRATORY THER.	_____		

33. DISCHARGE CARE PLANNING IF RESIDENT CAN BE DISCHARGED TO A LOWER LEVEL OF CARE, IS AN ALTERNATIVE PLACEMENT AVAILABLE? YES NO NA 1 2 3

34. COMMENTS SUPPORTING NURSING CARE NEED. DESCRIBING LESIONS & DECUBITI—(FOR ADDED COMMENTS, USE BACK OF NMPSRO COPY)

35. PATIENT STATUS IMPROVING 1 STABLE 2 UNSTABLE 3 DETERIORATING 4 CRITICAL 5 TERMINAL 6

Approval subject to eligibility and regulations in effect at time service is rendered.

UR AGENT

REVIEW INFORMATION 36. LEVEL OF CARE SNC 1 SNC WAIVER 2 IC 3 IC-MR 4 AWT PC 5

37. REVIEW DECISION APPROVED 1 DENIED 2 38. CRITERIA # _____

39. EFFECTIVE DATE _____ 40. DAYS _____ 41. EXPIRATION DATE M M D D Y Y 42. RC NO. _____ 43. PA NO. _____

44. PSRO SIGNATURE _____ 45. REVIEW DATE M M D D Y Y 46. DATE OF DISCHARGE M M D D Y Y

47. DISCHARGE STATUS 1 HOSP 2 SNF 3 ICF 4 INST OTH 5 HOME 6 HHA 7 LAMA 8 DIED 48. LTC FACILITY DISCHARGED TO _____

Physician may SIGN abstract to state need for level of care OR facility may attach physician's OTHER signed documentation such as current progress note, hospital discharge summary, etc.

49. ATTENDING PHYSICIAN LAST FIRST MI ADDRESS PHONE NO.

PHYSICIAN'S STATEMENT HISTORY & PHYSICAL OR LATEST PROGRESS NOTES + /OR ORDERS ATTACHED? YES NO DATE _____

I HAVE SEEN AND EVALUATED THIS PATIENT AND RECOMMEND: (CIRCLE ONE) HNF LNF ALTERNATE PLACEMENT PHYSICIAN'S SIGNATURE _____

ALL REVIEWS

ALL REVIEW CONT. STAY ONLY