

NORTH CAROLINA MEDICAID PROGRAM

LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

<input type="checkbox"/> PRIOR APPROVAL	<input type="checkbox"/> UTILIZATION REVIEW	<input type="checkbox"/> ON-SITE REVIEW
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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 NUMBER	
_____ HOME _____ DOMICILIARY _____ SNF _____ (REST HOME) _____ ICF _____ OTHER _____ HOSPITAL _____		_____ HOME _____ DOMICILIARY _____ SNF _____ (REST HOME) _____ ICF _____ OTHER		13. DATE APPROVED/DENIED	
14. DISCHARGE PLAN					
_____ SNF _____ HOME _____ ICF _____ (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	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		GASTROSTOMY
30 DAYS	CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	GRAND MAL	DRESSINGS:	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 & STRENGTHS, 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

22. DATE