BlueCross BlueShield of North Carolina

Treatment Plan Update for SNF, INPT REHAB (IRF), LTACH

FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

Patient Name: ____ Date: ________________________

BCBSNC Reference#: ____

Current Level of Care: SNF INPATIENT REHAB LTACH

Team Conference Day: M T W TH F

CM/SW Name: _____________________________________ **Phone/Fax:** _______________________________

Prior Living Conditions: INDEPENDENT SPOUSE SIG OTHER FAMILY/OTHER: _______________

Home Type: APT 1 STORY 2 STORY Stairs to enter (#): ______________

Owned Equipment (DME): Cane (SP/QUAD) ____; Walker ____; Rollator ____; W/C ____; Scooter ____; BSC ____; Reacher/Sock Aid ____; Other ____.

Brief Current Medical Status Update /Diagnosis/Medical Conditions/Co-Morbidities: (If there is a decline, please state reason)

Wounds: (please include location/size/ treatment/ dressing type & frequency):

IV Antibiotics: (please include name/frequency/duration):

Name: ________________________________ Frequency: _______________ Duration: ____________________

Name: ________________________________ Frequency: _______________ Duration: ____________________

Name: ________________________________ Frequency: _______________ Duration: ____________________

VENT Weaning/Respiratory (Answer if applicable):

Trach insertion date: __________________________

Vent Setting: FiO2 ___________ PEEP_____________ PS______________ TV______________ RATE_____________

Trach Collar Trials: YES NO

Trial/Date: ______________ Time **OFF** Vent (hours/min): ___________ Time **ON** Vent (hours/min): ___________

Trial/Date: ______________ Time **OFF** Vent (hours/min): ___________ Time **ON** Vent (hours/min): ___________

Trial/Date: _______________ Time **OFF** Vent (hours/min): ____________ Time **ON** Vent (hours/min): ____________

Trial/Date: _______________ Time **OFF** Vent (hours/min): ____________ Time **ON** Vent (hours/min): ____________

Trial/Date: _______________ Time **OFF** Vent (hours/min): ____________ Time **ON** Vent (hours/min): ____________

Bladder Mgt (circle): CONT INCONT I&O Caths Foley

Bowel Mgt Circle**)**: CONT INCONT

Bowel Program: YES NO

Other Bowel Needs: ___________________________

Speech Therapy (If applicable. Circle Status)

Comprehension:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Expression:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Memory:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP

Current Diet: PO/Consistency ____________________ Tube Feeding/Frequency: ___________________ Route: __________

Physical Therapy- Current Functional Level (Circle Status)

Weight Bearing Status: FULL NWB WBAT TTWB Status Duration: __________________

Bed Mobility:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Transfers:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Gait: Distance/ft ________	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP

Assistive Device: FW WALKER PF WALKER ROLLATOR CANE NONE OTHER _______________

W/C: Distance/ft ________	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Stairs: # of Steps ________	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP

Occupational Therapy- Current ADL Function (Circle Status)

Feeding:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
UB Bathing:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
LB Bathing:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
UB Dressing:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
LB Dressing:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Grooming:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Toileting:	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP
Transfers: (Tub/Shower/Toilet)	INDEP	MOD INDEP	SBA	CGA	MIN	MOD	MAX	DEP

Discharge Goals, Plans, & Caregiver Training: ____

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____

Discharge LEVEL of CARE: Acute Inpatient Rehab SNF Home Health Outpatient

Supervision needs: ____

Scheduled/Estimated Discharge Date: ____

Additional Notes (D/C Barriers): ____

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Caregivers Identified: Name: ____ph #_____________________________

Name: ____ ____________ ph# _____________________________

PROVIDER ATTESTATION: By signing below, I certify that the patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in the patient's medical records, BCBSNC may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

***Provider signature**: ______________________________ **Date:** _________________

Please fax form to 1-800-228-0838