Blue Cross and Blue Shield of Vermont (BCBSVT)
The Vermont Health Plan (TVHP)
New England Health Plan (NEHP)
Access Blue New England (ABNE)
State of Vermont
Fletcher Allen Health Care

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Initial Inpatient Rehabilitation Worksheet

A Prior Approval form must be used in addition to this worksheet. If you need more room you may attach additional pages/forms. If you have questions on the form or the member's benefits please visit our website at www.bcbsvt.com or call our customer service at (800) 924-3494 for assistance.

Section 1: Patient Information

Patient Name: _____ Date of Evaluation: ___/____/____

Section 2: Facility Information

Facility NPI: _____

Facility Phone Number: _(___)_____ Attending MD Phone: _(___)_____

Facility Address: _____

Contracted with local BCBS: ☐ Yes ☐ No Place of Service: ☐ SNF ☐ Acute Rehab ☐ LTCH/Chronic

Section 3: Admission Information

Requested Days: ☐ 5 ☐ 7 ☐ 10

Case Manager: _____ Case Manager Phone: _(___)_____

Contact Name: _____ Contact Phone: _(___)_____

Section 4: Clinical Information

Review of Acute Care Admission: _____

_____

_____

_____

Past Medical History: _____

_____

_____

Social History: _____

_____

_____

Section 5: Clinical Status/Treatment

Alert and Oriented (Circle one): Yes No Able to Follow Commands (Circle one): Yes No

Isolation (Circle one): Yes No Able to Participate in Treatment (Circle one): Yes No

Pain: ____/10 T: _____ P: _____ R: _____ BP: _____

☐ Trach O2Sat: _____% ☐ Suction Frequency: _____ xDay

☐ Vent F102: _____Prep: _____ ☐ Nebs Frequency: _____ xDay

☐ Wound Stage/Type _____ Length: _____ Width: _____ Depth: _____

☐ Wound Care Dressing Type: _____ Frequency: _____ xDay

☐ Enteral Feeds Percent Total Daily Calories ____% ☐ IV Meds _____ ____xDay

☐ TPN/PPN ☐ IV Therapy ☐ Rate _____cc/h _____xDay

Section 6: Labs/Diagnostic

WBC: _____ Neutrophills: _____ Hgb: _____ Hct: _____

PLT: _____ PT: _____ PTT: _____ INR: _____

Other Labs: _____ Other Tests: _____

☐ Cardiac Monitoring ☐ Chest X-Ray: Stable/Improving

Section 7: Current Level of Function/Treatment

	Independent	Supervision	Contact Guard	Min. Asst.	Mod Asst.	Max Asst.	Dep.
ADL							
Bed Mobility							
Transfers							
Ambulation							

Distance (in feet): _____ Device: ☐ Cane ☐ Walker ☐ Wheel Chair

# of Stairs: _____ Endurance: ☐ Good ☐ Fair ☐ Poor

☐ PT Frequency: _____ xHrs/Day: _____ Days/Wk: _____

☐ OT Frequency: _____ xHrs/Day: _____ Days/Wk: _____

☐ ST Frequency: _____ xHrs/Day: _____ Days/Wk: _____

Section 8: Goals (include any social barriers and concerns; attach additional sheets if necessary)

_____

_____

_____

_____

Section 9: Discharge Plan

Anticipated Discharge Date: _____/_____/_____ Medicaid App Initiated? ☐ Yes ☐ No

Discharge to: ☐ Acute Rehab ☐ SNF ☐ Home ☐ Hospice

Anticipated Discharge Needs: ☐ VNA ☐ HHA ☐ PT ☐ OT ☐ ST ☐ DME

Is there a Caregiver available? ☐ Yes ☐ No

Section 10: Form

Name of Person Completing Form/Office Contact: _____

Phone: _____ Fax: _____ Date: _____