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

# Inpatient Rehabilitation Continuation 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 and Facility Information

**EXISTING AUTH NUMBER:** _____

Patient Name: _____

Facility Phone Number: (  ) _____

Admit Date: __/__/_____

Date of Evaluation: __/__/_____ Requested Days: ☐ 5 ☐ 7 ☐ 10

Contact Name: _____ Contact Phone: (  ) _____

## Section 2: 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 Dialy Caolires ____% ☐ IV Meds_____ ____xDay

☐ TPN/PPN ☐ IV Therapy ☐ Rate_____cc/h _____xDay

## Section 3: Labs/Diagnostic

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

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

Other Labs: _____ Other Tests: _____

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

## Section 4: 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 5: Goals (include any social barriers and concerns; attach additional sheets if necessary)

_____

_____

## Section 6: 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