NC Medicaid Long Term Care FL2 Form

NC Medicaid-372-124

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____ 3. Recipient DOB:_____
4. Recipient ID #_____ 5. Recipient Gender:_____ 6. SSN: _____
7. Admission Date (current location):_____ 8. Facility Name:_____ 9. PASRR #: _____
10. Facility Address:_____ 11. Provider Number: _____
12. Attending Physician Name/Address: _____
13. Relative Name/Address:_____
14. Current Level of Care: ☐ Home ☐ SNF ☐ ICF ☐ Hospital ☐ Dom ☐ Other: _____
15. Requested Level of Care: ☐ Vent Care ☐ Nursing Facility ☐ NF Rehab ☐ Spec. Hosp Rehab ☐ Extended Care
☐ OOS NF ☐ OOS Vent ☐ CAP/CH SNF ☐ CAP/CH Hosp ☐ CAP/DA SNF ☐ CAP/DA ICF ☐ Other: _____
16. Discharge Plan: ☐ Home ☐ SNF ☐ ICF ☐ Dom ☐ Other: _____

Diagnosis Information

	Admitting Diagnosis (code AND description)	Date of Onset	Primary ✓)
1			
2			
3			
4			
5			

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**		☐ Gastronomy
☐ 30 Days	☐ Convulsions/Seizures	☐ Dressings:	☐ Intake and Output
☐ 90 Days	☐ Grand Mal		☐ Force Fluids
☐ Over 180 Days	☐ Petit Mal		☐ Weight
☐	☐ Frequency		☐ Height

Special Care Factors	Frequency	Special Care Factors	Frequency
☐ Blood Pressure		☐ Bowel & Bladder Program	
☐ Diabetic Urine Testing		☐ Restorative Feeding Program	
☐ PT (by licensed PT)		☐ Speech Therapy	
☐ Range of Motion Exercises		☐ Restraints	

Medications – Name & Strength, Dosage and Route	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

X-ray and Laboratory Findings/Date:

Additional Information:

_____ _____

Physician's Signature **Date**