louisiana healthcare connections™

Clinical Review Form

Member Information

First Name ______________________ Last Name ______________________

Medicaid ID # ______________________ Date of Birth (mm/dd/yyyy) ______________________

Phone ______________________ Age __________ Gender: ☐ Male ☐ Female

Facility Information

Facility Name ______________________ Contact Name ______________________

Authorization # ______________________ Phone ______________________

Admit Date ______________ ☐ Inpatient ☐ Observation

Location ☐ ER ☐ Direct Admit ☐ Same Day Surgery ☐ Outpatient Facility

Level of Care ☐ Acute ☐ Intermediate ☐ Critical ☐ Special Care Nurse ☐ NICU Level III ☐ NICU Level IV

Diagnosis ______________________

Symptoms/Findings/Medical History/Prior Outpatient Treatment ______________________

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Vital Signs (Oxygen Saturation On Room Air) ______________________ O2 ______________________

Monitoring (Cardio/Respiratory, ICP, Neuro, Invasive) ______________________

Diet ______________________ Activity ______________________

Abnormal Labs/Diagnostics/Culture Results/Procedures ______________________

____

Medications (Dosage, Route, Frequency) ______________________

____

Tubes, Drains, Lines ______________________

IV Fluids (IVGs, Additives, TPN) ______________________

Discharge Plan ______________________

____

____

Discharge Date ______________________ Anticipated D/C Needs ______________________

Barriers to D/C ______________________

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Please fax the completed form to: 1-877-668-2080

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