**INPATIENT ACUTE**

**REQUIRED PA INFORMATION**

1. Provider Contact Name:
2. Provider Contact Number:
3. Is This a Retro Review? Yes / No
   1. If Retro Request, Date Notified of Medicaid Eligibility:
   2. Is this Medicare exhaustion or denial:
4. Reason For the Admission / Pertinent Medical History ( Please Include If Dyspnea With Chest Pain):
5. Presenting Clinical Signs and Symptoms:
6. Full Vital Signs (Temperature, BP, P, RR, Pulse Oximetry on Room Air):
7. Abnormal Diagnostic Studies: Labs, Imaging, EKG Results:
8. Prior Outpatient Treatment ( Including Medications Prescribed in Last 72 Hours):
9. Surgical Admission:
10. Name of Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Surgery to be Performed Day of Admission? Yes / No

If No –Explain:

1. IF OB/Pre-Term Labor Please Provide: Monitoring Frequency/Cervical Changes/Duration & Frequency Contractions/Day:
2. Indicate Unit That Patient Admitted to For Example ICU or Telemetry:
3. IV Fluid Ordered, Including Rate:
4. IV Medications Ordered( Frequency, Indicate PRN and Doses in First 24 Hours):
5. Supplemental Oxygen Therapy, Including Spot Checks or Continuous Monitoring:
   1. O2 – How Many Liters / Minute
   2. Frequency and Type of Nebulizer Treatments Order
6. Is Patient Receiving Neuro Check / What Frequency:
7. Pending Cultures:
8. Anti-Infectives Ordered and Given:
9. Other MD Physician Orders and Other Treatments:

19. Please Describe Any Other Pertinent Information Related to This PA Request: