

QUALIDIGM/CONNCUR/MEDICAID FAX REVIEW

FAX #: (860) 635-3628

TODAYS DATE: _____

HOSPITAL: _____

CONNCUR AUTHORIZATION #: _____

PATIENT FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

SEX: M _____ **F** _____

MEDICAID #: _____

ACTIVE: YES _____ **NO** _____

M.D.'S FULL NAME: _____

M.D. LICENSE #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE #: _____

DATE OF ADMIT: _____ **TIME OF ADMIT:** _____ **a.m./p.m. (circle)**

TYPE OF ADM. (circle): **E.R. DIRECT ELECTIVE**

PREV. D/C DATE WITHIN LAST 30 DAYS _____

REVIEWER NAME : _____

TELEPHONE #: _____

DIAGNOSIS: _____

PAST MEDICAL HISTORY: _____

SYMPTOMS: T _____ **P** _____ **R** _____ **BP** _____ **02 SAT** _____ **% O2:** _____ **ABG** _____

ER TX: _____

INPATIENT TREATMENT: IVF RATE _____ **(CIRCLE ONE) OBSERVATION ICU TELEMETRY FLOOR**

IV MEDS: _____

ABNORMAL LABS: **WBC:** _____ **Hgb:** _____ **PLT:** _____ **NA:** _____ **CL:** _____ **BUN:** _____ **GLU:** _____ **SLIDING SCALES:** _____

RBC: _____ **Hct:** _____ **K+:** _____ **CO2:** _____ **CR:** _____

OTHER: _____

Radiology Results