# Personal Care Pre-Admission Screening Form

**Facility/Agency/Person making referral:**

Name: _____ Address: _____

Contact Person: _____

Phone: ( ) _____ Fax: ( )_____

**Check only one**: Personal Care □ Initial □ Re-evaluation

## I. DEMOGRPAHIC INFORMATION

| **1 Individual's Full Name** | **2. Sex:** □Female □Male | **3. Medicaid Number** | | **4. Medicare Number** |
|---|---|---|---|---|
| **5. Address: (Including Street/Box, City, State & Zip** | | | | **6. Private Insurance** |
| **7. County** | **8. Social Security Number** | **9. Birth Date** | **10. Age** | **11. Phone #** |
| **12. Spouse's Name** | | **13. Address (if different from above)** | | |
| **14. Current living arrangements, including formal and informal support (i.e. family, friends, other services)** | | | | |
| **15. Name and Address of Provider if Applicable:** | | | | |

**16. Medicaid Waiver Recipient: A.□ Yes B. □ No C. □ Aged/Disabled D. □ I/DD**
**17. Has the option of Medicaid Waiver been explained to the applicant? A. □ Yes B. □ No**
**18. Check if Applicant has any other of the following:**

a. □ Guardian
b. □ Committee
c. □ Medical Power of Attorney
d. □ Power of Attorney □ Other
e. □ Durable Power of Attorney
f. □ Living Will

Name

Address of the Representative:

Phone Number: ( ) _____

**19. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the physician to Department of Health and Human Resources or its representative.**

**X**_____ _____ _____
**Signature – Applicant or Person acting for Applicant** **Relationship** **Date**

**Date:**

**Name:**

**MEDICAL ASSESSMENT**

**20. Health Assessment – Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(s) with dates – Date of most recent office visit. (Attach most recent Hospital Discharge and Physical, if available)**

**21. Normal vital Signs for the Individual:**

a. Height b. Weight: c. Blood Pressure d. Temperature e. Pulse f. Respiratory Rate

**Check if Abnormal:**

a. □ Eyes
b. □ Ears
c. □ Nose
d. □ Throat
e. □ Mouth
f. □ Neck
g. □ Breast
h. □ Lungs
i. □ Heart
j. □ Arteries
k. □ Veins
l. □ Lymph System
m. □ Extremities
n. □ Abdomen
o. □ Hernia(s)
p. □ Genitalia-Male
q. □ Gynecological
r. □ Ano-Rectal
s. □ Musculo-Skeletal
t. □ Skin
u. □ Nervous System
v. □ Allergies (Specify)

**Describe Abnormalities and Treatment:**

**23. Medical Conditions/Symptoms: (Check all that apply and have been diagnosed by a physician and/or treated with prescription medications.)**

a. □ Angina-rest
b. □ Angina-exertion
c. □ Dyspnea
d. □ Significant Arthritis
e. □ Paralysis
f. □ Dysphagia
g. □ Aphasia
h. □ Pain
i. □ Diabetes
j. □ Contracture(s)
k. □ Mental Disorder(s)
l. □ Other (Specify)

**24. Decubitus: a. □ Yes b. □ No If yes, check the following:**

A. Stage B. Size C. Treatment

Location:

a. □ Left Leg
b. □ Left Arm
c. □ Right Leg
d. □ Right Arm
e. □ Left Hip
f. □ Left Buttock
g. □ Right Hip
h. □ Right Buttock

Other: ☐ Developed at: a. □ Home b. □ Hospital c. □ Facility

**25. Can the individual vacate the building? (Check only one)**

a. □ Independently b. □ With Supervision c. □ Mentally Unable d. □ Physically Unable

**Date:**

**Name:**

**26. Indicate individual's ability in the home for each item with the level number 1,2,3, or 4. Nursing care plan must reflect functional abilities of the member in the home.**

| Item | Level 1 | Level 2 | Level 3 | Level 4 |
|---|---|---|---|---|
| a. Eating (Not a meal Prep) | Self/Prompting ☐ | Physical Assistance ☐ | Total Feed ☐ | Tube Feed ☐ |
| b. Bathing | Self/Prompting ☐ | Physical Assistance ☐ | Total Care ☐ | |
| c. Dressing | Self/Prompting ☐ | Physical Assistance ☐ | Total Care ☐ | |
| d. Grooming | Self/Prompting ☐ | Physical Assistance ☐ | Total Care ☐ | |
| e. Cont./Bladder | Continent ☐ | Occasional Incontinenc ☐ | Incontinent ☐ | Catheter ☐ |
| f. Cont./Bowel | Continent ☐ | Occasional incontinenc ☐ *less than 3 X per week | Incontinent ☐ | Colostomy ☐ |
| g. Orientation | Oriented ☐ | Intermittently disorient ☐ | Totally Disoriented ☐ | Comatose ☐ |
| h. Transferring | Independent ☐ | Supervised/Assistive Device ☐ | One Person Assist ☐ | Two Person Assis ☐ |
| i. Walking | Independent ☐ | Supervised/Assistive Device ☐ | One Person Assist ☐ | Two Person Assistance ☐ |
| j. Wheeling | No Wheelchair ☐ | Wheels Independently ☐ | Situational Assistance (Doors, etc.) ☐ | Total Assistance ☐ |
| k. Vision | Not Impaired ☐ | Impaired/Correctable ☐ | Impaired/Not Correctable ☐ | Blind ☐ |
| l. Hearing | Not impaired ☐ | Impaired/Correctable ☐ | Impaired/Not Correctible ☐ | Deaf ☐ |
| m. Communication | Not impaired ☐ | Impaired/Understandal ☐ | Understandable wi Aids ☐ | Inappropriate/No ☐ |

**27. Professional and technical care needs – check all that apply:**

| | | |
|---|---|---|
| a. □ Physical Therapy | f. □ Ostomy | k. □ Parenteral Fluids |
| b. □ Speech Therapy | g. □ Suctioning | l. □ Sterile Dressing |
| c. □ Occupational Therapy | h. □ Tracheostomy | m. □ Irrigations |
| d. □ Inhalation Therapy | i. □ Ventilator | n. □ Special Skin Care |
| e. □ Continuous Oxygen | j. □ Dialysis | o. □ Other |

**28. Individual is capable of administering his/her own medication:**
a. □ Yes b. □ With Prompting/Supervision c. □ No

| 29. Current Medications | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Date**:

**Name**:

**30. Current Diagnoses – Check all that apply:**

a. □ None
b. □ Mental Retardation
c. □ Autism
d. □ Seizure Disorder (Age at onset( )
e. □ Cerebral Palsy
f. □ Other Developmental Disability: Specify

g. □ Schizophrenic Disorder
Specify:

h. □ Paranoid Disorder
i. □ Major Affective Disorder
j. □ Schizoaffective Disorder
k. □ Affective Bipolar Disorder
l. □ Tardive Dyskinesia
m. □ Major Depression
n. □ Other related conditions

**31. Clinical and Psychosocial Data – Please check any of the following behaviors which the individual has exhibited in the past two years.**

a. □ Substance Abuse
(Identify)

b. □ Combative
c. □ Withdrawn/Depressed
d. □ Hallucinations
e. □ Delusional
f. □ Disoriented
g. □ Bizarre Behavior
h. □ Bangs Head
i. □ Sets Fires
j. □ Displays inappropriate Social Behavior
k. □ Seriously Impaired Judgment
l. □ Suicidal Thoughts, Ideations/Gestures
m. □ Cannot Communicate Basic Needs
n. □ Talks about his/her Worthlessness
o. □ Unable to Understand Simple Commands
p. □ Physically Dangerous to Self and Others, if unsupervised
q. □ Verbally Abusive
r. □ Demonstrates Severe Challenging Behaviors
s. □ Specialized Training Needs
t. □ Sexually Aggressive

**Does the individual have Alzheimer's multi-infarct, senile dementia, or related condition?** □ Yes □ No
□ Other (Specify):

## II. PHYSICIAN RECOMMENDATION

**32. Prognosis: Check one only:** a. □ Stable b. □ Improving c. □ Deteriorating d. □ Terminal
Diagnosis:

**Rehabilitative Potential – Check one only: a.** □ Good b. □ Limited c. □ Poor

**33. Other Medical Conditions Requiring Physician Orders:**

**To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D., D.O, Physician Assistant, or Nurse Practitioner)**

| | |
|---|---|
| **Physician's Signature** **MD/DO** | **TYPE OR PRINT** Physician's Name/Address below |
| **Date** | |

**34. RN Signature and Date:** _____

**DISCLAIMER:** Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan
**NOTE:** Information gathered from this form may be utilized for statistical/data collection.