Personal Care Pre-Admission Screening Form

Facility/Agency/Person	making referral:			
Name:	Ac	ldress:		
Contact Person:				
Phone: ()	Fa:	k: ()		
Check only one: Person	nal Care 🛛 Initial 🗆 Re-eval	uation		
I. DEMOGRPA	HIC INFORMATION			
1 Individual's Full Name	2. Sex: □Female □Male	3. Medicaid I	Number	4. Medicare Number
5. Address: (Including Stre	et/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. Addr	ess (if diffe	rent from above)
15. Name and Address of Pr	nents, including formal and in			y, menus, other services
	ient: A. Yes B. No C. caid Waiver been explained to any other of the following:			
a. 🗆 Guardian	any other of the following.		ver of Attorn	
b. 🗆 Committee			rable Power	of Attorney
c. □ Medical Power of A Name	ttorney	f. 🗆 Liv	ring Will	
Address of the Representative	e:			
	rmining my need for appropri an to the physician to Departi			
X Signature – Applicant or Pe	rson acting for Applicant	Relation	nship	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 f. Respiratory Rate e. Pulse Check if Abnormal: a. □ Eyes g. 🗆 Breast m. \Box Extremities s.

Musculo-Skeletal n. 🗆 Abdomen b. □ Ears h. 🗆 Lungs t. 🗆 Skin c. 🗆 Nose o. 🗆 Hernia(s) i. 🗆 Heart u. 🗆 Nervous System d. 🗆 Throat j. 🗆 Arteries p. 🛛 Genitalia-Male v. 🗆 Allergies e. 🗆 Mouth k. 🗆 Veins q. 🗆 Gynecological (Specify) f. \Box Neck 1. 🗆 Lymph System r. 🗆 Ano-Rectal **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 e. Deralysis i. Diabetes f. 🗆 Dysphagia b.
□ Angina-exertion i. \Box Contracture(s) k.
□ Mental Disorder(s) c. Dyspnea g. 🗆 Aphasia d. 🗆 Significant Arthritis h. 🗆 Pain 1. \Box Other (Specify) 24. Decubitus: a. 🗆 Yes **b.** \square No If yes, check the following: A. Stage B. Size C. Treatment Location: a. 🗆 Left Leg g. 🗆 Right Hip c. \Box Right Leg e. \Box Left Hip d. 🗆 Right Arm b. \Box Left Arm f. \Box Left Buttock h. \Box Right Buttock Other: Developed at: $a. \square$ Home b. \Box Hospital c. \Box Facility 25. Can the individual vacate the building? (Check only one) a. □ Independently b. \square With Supervision d. D Physically Unable c. □ Mentally Unable

Date:

Name:

It	em	Level 1		Level 2	Level 3	3	Level 4
•	Eating (Not a meal Prep)	Self/Prompting	g	Physical Assistance	Total F	eed	Tube Feed
•	Bathing	Self/Prompting	g	Physical Assistance	Total C	Care	
	Dressing	Self/Prompting	g	Physical Assistance	Total C	lare	
•	Grooming	Self/Prompting	g	Physical Assistance	Total C	Care	
•	Cont./Bladder	Continent		Occasional Incontinence	Inconti	inent	Catheter
	Cont./Bowel	Continent		Occasional incontinence *less than 3 X per week	Inconti	inent	Colostomy
•	Orientation	Oriented		Intermittently disoriented	Totally	Disoriented	Comatose
•	Transferring	Independent		Supervised/Assistive Device	One Person Assist		Two Person Assist
	Walking	Independent		Supervised/Assistive Device	One Person Assist		Two Person Assistance
	Wheeling	No Wheelchair		Wheels Independently	Situational Assistance (Doors, etc.)		Total Assistance
•	Vision	Not Impaired		Impaired/Correctable		ed/Not table	Blind
					Impaired/Not Correctible		
	Hearing	Not impaired		Impaired/Correctable			Deaf
1.	Communication	Not impaired		Impaired/Correctable Impaired/Understandable	Correct		
27	Communication	Not impaired technical care r apy y	f. □ (g. □ \$ h. □ 1 i. □ V		Correct	tible standable with □ Parenteral I □ Sterile Dres . □ Irrigations	Inappropriate/Nor Pluids sing
27	Communication	Not impaired technical care i rapy y m able of administ Prompting/Super	f (g (h) i 1 j 1	Impaired/Understandable - check all that apply: Dstomy Suctioning Tracheostomy Ventilator Dialysis his/her own medication: c. □ No	Correct Unders Aids k. l. m n. o.	tible standable with Parenteral I Sterile Dres Irrigations Special Skin	Inappropriate/Non Pluids sing
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Date:

		Name:
0. Cur	rrent Diagnoses – Check all that ap	ply:
a. b. c. d. e.	 None Mental Retardation Autism Seizure Disorder (Age at onset(Cerebral Palsy Other Developmental Disability: Sp 	 h. □ Paranoid Disorder i. □ Major Affective Disorder j. □ Schizoaffective Disorder) k. □ Affective Bipolar Disorder 1. □ Tardive Dyskinesia
	 Schizophrenic Disorder Specify: 	
		e check any of the following behaviors which the individual has
	ed in the past two years.	
	Substance Abuse (Identify)	 k. □ Seriously Impaired Judgment l. □ Suicidal Thoughts, Ideations/Gestures m. □ Cannot Communicate Basic Needs
	Combative	n. 🛛 Talks about his/her Worthlessness
	Withdrawn/Depressed	o. 🛛 Unable to Understand Simple Commands
d.	Hallucinations	p. D Physically Dangerous to Self and Others, if
e.	🗆 Delusional	unsupervised
f.	Disoriented	q. 🗆 Verbally Abusive
	D' D1 '	
g.	Bizarre Behavior	r. 🛛 Demonstrates Severe Challenging Behaviors
0	 Bizarre Benavior Bangs Head 	 r. □ Demonstrates Severe Challenging Behaviors s. □ Specialized Training Needs
h.		
h. i. j.	 Bangs Head Sets Fires Displays inappropriate Social Behave 	s.
h. i. j. Does th o Other	 Bangs Head Sets Fires Displays inappropriate Social Behave individual have Alzheimer's multic (Specify): PHYSICIAN RECOMMENDAT 	s. Specialized Training Needs t. Sexually Aggressive vior i-infarct, senile dementia, or related condition? Yes No TION
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h. i. j. Ooes the Other B2. Prog Diagnos: Rehabili B3. Oth	 Bangs Head Sets Fires Displays inappropriate Social Behave e individual have Alzheimer's multic (Specify): PHYSICIAN RECOMMENDATION PHYSICIAN RECOMMENDATION Physician (Stable) gnosis: Check one only: a. Stable is: Stative Potential – Check one only: her Medical Conditions Requiring Physician (Stable) 	s. □ Specialized Training Needs t. □ Sexually Aggressive vior i-i-infarct, senile dementia, or related condition? □ Yes □ No TION e b. □ Improving c. □ Deteriorating d. □ Terminal a. □ Good b. □ Limited c. □ Poor hysician Orders:
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h. i. j. Does the Other B2. Prog Diagnos: Rehabilition of the base of t	 Bangs Head Sets Fires Displays inappropriate Social Behave e individual have Alzheimer's multice (Specify): II. PHYSICIAN RECOMMENDATE gnosis: Check one only: a. Stable Stable Stable Stable itative Potential – Check one only: her Medical Conditions Requiring Places of my knowledge, the patient's ed by M.D. or D.O) 	s. □ Specialized Training Needs t. □ Sexually Aggressive vior i-infarct, senile dementia, or related condition? □ Yes □ No TION e b. □ Improving c. □ Deteriorating d. □ Terminal a. □ Good b. □ Limited c. □ Poor hysician Orders: s medical and related needs are essentially as indicated above (Must TYPE OR PRINT Physician's Name/Address below

NOTE: Information gathered from this form may be utilized for statistical/data collection. **WV-BMS-PC-Pre-Admission Screening - January 2014 – Revised 6/10/2014**