**Pre-Admission Screening / Resident Review**
**Medical Evaluation for Persons with Mental Illness**

| _____ | _____ | ___/___/___ | _____ |
|---|---|---|---|
| (Last Name) (First Name) (Middle) | (Medicaid ID Number) | (Birthdate) | (Sex) |
| _____ | _____ | _____ | _____ |
| (Home Address) | (City) | (State) | (Zip) |

Your patient's medical and psychiatric diagnosis and/or treatment regime may necessitate a determination to be made by the Department of Heath/Adult Mental Health Division regarding your need for nursing facility placement and psychiatric "active specialized treatment". A complete medical and psychiatric evaluation is needed to make this determination.

LICENSED PHYSICIAN: Please complete all subsequent items on this form or enclose copy of a recent medical history/physical record.

| SIGNIFICANT HISTORY AND MAJOR ILLNESSESS | | | |
|---|---|---|---|
| Diagnosis/Illness/Problem | Date of Treatment | Medication and Treatment | Prognosis |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does the patient have any medication allergies? ___ Yes ___ No. If yes, list allergies:

| Medication and Allergic Reaction | |
|---|---|
| Medication | Reaction |
| | |
| | |

Is patient currently receiving psychoactive medication? __ Yes __ No. If yes, list the drug, reason, potential side effects and date.

| Name of Psychoactive Medication | Reason Drug is Prescribed | Start Date | Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| What is this patient's ability to perform ADLs in the community and describe the level of support needed to perform activities in the community: |
|---|
| |

| _____ MD | _____ MD | _____ |
|---|---|---|
| Examining Physician (Print or Type) | Signature of Physician | Date |

Physical Exam: Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

| Normal | Check each item in the appropriate Column. Enter "NE" if not evaluated | Abnormal | Findings |
|---|---|---|---|
| | Head, Face, Neck, and Scalp | | |
| | Nose, Throat, and Mouth | | |
| | Sinuses | | |
| | Ears, General | | |
| | Hearing: Right ____ Left ____ | | |
| | Ophthalmoscopic | | |
| | Pupils | | |
| | Vision: Far _____ Near _____ | | |
| | Lungs and Chest | | |
| | Heart | | |
| | Vascular System | | |
| | Abdomen and Viscera | | |
| | Anus and Rectum | | |
| | Endocrine System | | |
| | G-U System | | |
| | Upper Extremities | | |
| | Lower Extremities | | |
| | Feet | | |
| | Spine, Other Musculoskeletal | | |
| | Identifying Body Marks, Tatoos, Scars | | |
| | Skin, Lymphatics | | |
| | | | |
| | NEUROLOGICAL | | |
| | Motor (station, gait, power, coordination) | | |
| | Sensory (pain, temperature, touch, deep pain and vibratory sense) | | |
| | Reflexes (superficial) | | |
| | (deep) | | |
| | (pathological) | | |
| | | | |
| | Cranial Nerves: | | |
| | I | | |
| | II | | |
| | III, IV, VI | | |
| | V | | |
| | VII | | |
| | VIII | | |
| | IX, X, XI | | |

Level of Care SNF _____ ICF _____ HOSPICE _____ DEFERRED _____ OTHER (Specify) _____
Physical Diagnosis: _____

_____ MD _____ MD _____
Examining Physician (Print or Type) Signature of Physician Date