State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

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/APRN: 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:

_____	_____	_____
Physician/APRN Name & Title (Print)	Signature of Physician/APRN	Date
_____	_____	
Co-signing Physician Name (Print)	Co-signature of Physician (Required for APRN assessor)	

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: _____

_____ _____ _____

Physician/APRN Name & Title (Print) Signature of Physician/APRN Date

_____ _____

Co-signing Physician Name (Print) Co-signature of Physician
(Required for APRN assessor)