

Instructions to the Examining Provider

Your patient is applying for services from the Department of Human Service (DHS). You are requested to complete this form so that the Office of Medical Review (OMR) can determine the **Level of Care**.

Documentation is required to assist in rendering services that best meet this client's **current** needs, either in a Nursing Facility or with Community Services.

What is needed from you to ensure completion of this application:

- 1. Please complete this PM-1 thoroughly, returning it to the designated Long Term Care Office in a timely manner. **All sections must be completed.**
- 2. The PM-1 is essential; other medical information is encouraged, i.e. medication sheets, but not in substitution of this form.

As the examining provider (MD, DO, RNP, PA) you will be assessing your patient's **medical diagnosis**, **current functional activity**, **cognitive status and treatments**. (Please use the included codes on page 3.)

Thank you in advance of your assistance.

Activities of Daily Living(See Current Functional Activities)

TRANSFER: ability to move between surfaces. To or from, bed, chair, wheelchair, standing position excluding to/from bath or toilet (with or without assisted device)

AMBULATION: ability to move between locations in the individual's living environment (with or without assisted device)

BED MOBILITY: ability to reposition body, turning side to side

DRESSING: ability to put on, fasten and take off all items of clothing

BATHING: ability to take a bath, shower, or sponge bath (effectively and thoroughly) and ability to transfer in/out of tub or shower (with or without assistance device)

TOILETING: ability to transfer on/off toilet, cleanses self after elimination, change pad/brief, manage ostomy or catheter, and adjust clothes

EATING: ability to eat and drink using routine or adaptive utensils (this also includes the ability to cut, chew and swallow food)

PERSONAL HYGIENE: ability to comb hair, brush teeth, wash and dry face, hands and perineum

MEDICATION MANAGEMENT: ability to identify and take medications correctly at the right time, route and dose



Provider Medical Statement

Date	Date of Last Office Visit	
Applicant Name:	Date of Birth	
SS# or MID:	Gender (circle): Male Female	
Address:	Apt./Floor:	
City/Town:	State: Zip Code:	
Current Living Arrangement (circle one	e): Lives Alone Lives with Others Other:	
Name of Facility	Date Admitted:	
DIAGNOSIS: Medical & Behavioral (i	ncluding severity of condition) *NO DIAGNOSIS CODES	
PRIMARY DIAGNOSIS (Dates)	OTHER DIAGNOSIS (Dates) SURGERY/INFECTIONS (include dates)	
Prognosis of Rehabilitation Potential: Permanent Disability: \[\sum \text{Yes} \text{No} \]		
MEDICATIONS: Name, Dose, Freque	ency, and Route	
PAIN ASSESSMENT		
	10 Diagnosis: Frequency vere)	
Does pain interfere with individual's activity or movement? Yes No		
Is pain relieved by medications/treatmer		
- · · ·		
PRESENT TREATMENTS & FREQUENCY Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)		
Therapies:	Wound Care: site(s)	
PTx's/wk for/wk's OTx's/wk for/wk's STx's/wk for/wk's	(treatment) Pressure Ulcers #	
ST x's/wk fo r /wk's	Stage Size cm	
Respiratory Therapy	Bladder & Bowel Training	
Oxygen Liters PRN □ Cont □	Incontinence:	
Chemotherapy/Radiation □	Bladder □ Yes □ No Frequency	
Dialysis □	Bowel □ Yes □ No Frequency	
Diet	Falson D Calcadaman D Haradaman D	
Tube Feeding		

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Current Functional Activity (Codes		
 0 = INDEPENDENT: NO TALK, NO TOUCH No help or oversight provided to the individual during the activity (with or without the supplied of the individual during the activity (with or without the supplied of the individual during the activity (device) 			
2 = LIMITED ASSISTANCE: TALK AND TOUCH Individual highly involved in activity, received physical guided assistance, no lifting	g of any part of the individual		
3 = EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT Individual performed part of activity but caregiver provides physical assistance to life.	t, move or shift individual		
4 = TOTAL DEPENDENCE: ALL ACTION BY CAREGIVER Individual does not participate in any part of the activity			
5 = ACTIVITY DID NOT OCCUR: NO ACTION The activity was not performed by the individual or caregiver	USE THESE CODES		
Activities of Daily Living (ADL's)	Instrumental (ADL's)		
Bed Mobility	Housekeeping		
Dressing	Meal Prep		
Bathing	Shopping		
Toileting Eating	Laundry		
Personal Hygiene Medication Management			
Please circle all that apply:			
Ambulation Cane, Walker, Wheelchair, Bed Bedridden, Fall Risk	l to Chair,		
Can the patient go out unaccompanied? Can the patient utilize public transportation independently?	 □ Yes □ No □ Yes □ No 		
COGNITIVE STATUS			
Is the patient impaired? ☐ Yes ☐ No MMSE Score BIMS	S Score Date		
Cognitive Skills for Daily Decision Making (please check one) □ Independent: □ Modified Independence: □ Moderately Impaired: □ Severely Impaired:			
Behaviors: Please circle all that apply. Please include level of severity on the line provided: 1 = Mild 2 = Moderate 3 = Severe			
Disoriented Agitated Wander Memory Loss Verbally Aggressive Other Resists Care Physically Aggressive	Elopement Safety Risk		
Is patient followed by psych services: Yes No If yes, where?			
Has patient been hospitalized for Psychiatric Diagnosis? $\ \square$ Yes $\ \square$ No	(If yes, give details below.)		
Date: Hospital: Diagnos			
If nursing home placement is medically necessary, will the patient be like months? \Box Yes \Box No	ely to return to the community within 6		
Provider's Name (print) Signature: (MD, DO, RNP, PA)	Date:		
For Office Use Only			
Social Caseworker: District Office	e:		
Date form sent to Provider: Date Receive			