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): **Lives Alone** **Lives with Others** **Other:** _____

Name of Facility _____ **Date Admitted:** _____

DIAGNOSIS: Medical & Behavioral (including severity of condition) *NO DIAGNOSIS CODES

PRIMARY DIAGNOSIS (Dates)	OTHER DIAGNOSIS (Dates)	SURGERY/INFECTIONS (include dates)

Prognosis of Rehabilitation Potential: _____

Permanent Disability: ☐ **Yes** ☐ **No**

MEDICATIONS: Name, Dose, Frequency, and Route

PAIN ASSESSMENT

0 1 2 3 4 5 6 7 8 9 10 **Diagnosis:** _____ **Frequency** _____

(none) **(moderate)** **(severe)**

Does pain interfere with individual's activity or movement? ☐ **Yes** **No** ☐

Is pain relieved by medications/treatment? ☐ **Yes** **No** ☐

PRESENT TREATMENTS & FREQUENCY

Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)

Therapies:

PT _____ **x's/wk for** _____ **/wk's**

OT _____ **x's/wk for** _____ **/wk's**

ST _____ **x's/wk fo r** _____ **/wk's**

Respiratory Therapy _____

Oxygen Liters ____ **PRN** ☐ **Cont** ☐

Chemotherapy/Radiation ☐

Dialysis ☐

Diet _____

Tube Feeding _____

Wound Care: **site(s)** _____

(treatment) _____

Pressure Ulcers # _____

Stage _____ **Size** _____ **cm**

Bladder & Bowel Training ☐

Incontinence:

Bladder ☐ **Yes** ☐ **No** **Frequency** _____

Bowel ☐ **Yes** ☐ **No** **Frequency** _____

Foley ☐ **Colostomy** ☐ **Urostomy** ☐

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 use of an assistive device)

1 = SUPERVISION: TALK, NO TOUCH
Oversight, cueing, and encouragement provided to the individual during the activity (with or without the use of an assistive device)

2 = LIMITED ASSISTANCE: TALK AND TOUCH
Individual highly involved in activity, received physical **guided assistance, no lifting** of any part of the individual

3 = EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT
Individual performed part of activity **but** caregiver provides physical assistance to **lift, 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)

_____ Bed Mobility
_____ Dressing
_____ Bathing
_____ Toileting
_____ Eating
_____ Personal Hygiene
_____ Medication Management
_____ Ambulation
_____ Transfer

Please circle all that apply:
Cane, Walker, Wheelchair, Bed to Chair, Bedridden, Fall Risk

Instrumental (ADL's)

_____ Housekeeping
_____ Meal Prep
_____ Shopping
_____ Laundry

Can the patient go out unaccompanied? ☐ **Yes** ☐ **No**
Can the patient utilize public transportation independently? ☐ **Yes** ☐ **No**

COGNITIVE STATUS

Is the patient impaired? ☐ **Yes** ☐ **No** **MMSE Score _____** **BIMS Score _____** **Date _____**

Cognitive Skills for Daily Decision Making (please check one)

☐ **Independent:** **Decisions consistent/reasonable**
☐ **Modified Independence:** **Some difficulty in new situations only**
☐ **Moderately Impaired:** **Decision poor/cue/supervision required**
☐ **Severely Impaired:** **Never/Rarely makes decisions**

Behaviors: Please circle all that apply.
Please include level of severity on the line provided: 1 = Mild 2 = Moderate 3 = Severe

____ Disoriented **____ Agitated** **____ Wander** **____ Elopement** **____ Safety Risk**
____ Memory Loss **____ Verbally Aggressive** **____ Other**
____ Resists Care **____ Physically Aggressive**

Is patient followed by psych services: □ **Yes** □ **No** **If yes, where? _____**

Has patient been hospitalized for Psychiatric Diagnosis? □ **Yes** □ **No** **(If yes, give details below.)**

Date: _____ Hospital: _____ Diagnosis: _____
_____

If nursing home placement is medically necessary, will the patient be likely to return to the community within 6 months? ☐ **Yes** ☐ **No**

Provider's Name (print) _____ Signature: _____ Date: _____
(MD, DO, RNP, PA)

For Office Use Only

Social Caseworker: _____ District Office: _____
Date form sent to Provider: _____ Date Received: _____