PreAdmission Screening Tool

Developmentally Disabled/Physically Disabled 12+

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age			
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Additional Information			
1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO

I. Intake Information

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

2.	If in an acute care facility, is discharge imminent (within 7 days)?	☐ YES	☐ NO
	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
4.	Number of Emergency Room visits in last 6 months(EPD)		
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)		
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					
Address					
City		State		Zip Code	

I. Intake Information

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

Phone Number(s)	

Customer Name Person ID

II. FUNCTIONAL ASSESSMENT

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

Give credit for the highest level of a skill which is **performed at least 75 percent of the time**. Only give credit for what the individual actually does, not for what the individual "can do" or "might be able to do." When a question groups many activities, rate the individual on his/her ability to complete the task as a whole.

HAND USE

If individual has one hand or use of one hand only, rate better hand.

☐	0	Uses fingers independently of each other
☐	1	Uses thumbs and fingers of hand(s) in opposition
☐	2	Uses raking motion or grasps with hand(s)
☐	3	No functional use of hand(s)

Comments:	

AMBULATION

Use of special assistive devices (e.g., canes, walkers, braces) should not affect rating.

☐	0	Walks well alone for normal distances and on all terrains
☐	1	Walks well alone for a short distance (10 - 20 feet); balances well; distance limitation may be due to terrain.
☐	2	Walks unsteadily alone for a short distance (10 - 20 feet)
☐	3	Walks only with physical assistance from others
☐	4	Does not walk

Comments:	

WHEELCHAIR MOBILITY

Wheelchair may be motorized or manual.

☐	0	Wheelchair is not used or moves wheelchair independently
☐	1	Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering)

Customer Name Person ID

☐ 2	Individual needs some, but not total assistance, in moving wheelchair
☐ 3	Needs total assistance for moving wheelchair

Comments:	

TRANSFER

Degree of human assistance necessary on a consistent basis for transfer, such as assistance in getting into wheelchair, getting on and off toilet, into and out of bed, in and out of shower/tub. Rate these items ONLY with regard to the need for human intervention, NOT with regard to the need for assistive devices. Ability to transfer in and out of a vehicle is not rated.

☐ 0	No problem in this area; does transfer self independently but may require use of assistive devices
☐ 1	Needs hands-on physical guidance, but does not have to be physically lifted, OR needs supervision with more than half of transferring activities
☐ 2	Needs to be physically lifted or moved, but can participate physically
☐ 3	Must be totally transferred by one or more persons OR is bedfast

Comments:	

EATING/DRINKING

Rate tasks involved in eating food and/or drinking beverages served.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food)
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance)
☐ 3	Does not perform this task even when assisted; is fed
☐ 4	Individual is tube fed

Comments:	

Customer Name Person ID

DRESSING

Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes)
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners)
☐ 3	Is not able to actively perform any part of this task but can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

PERSONAL HYGIENE

Those tasks involved in basic grooming, including hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands on assistance to comb hair).
☐ 3	This task must be done for the individual but individual can physically participate
☐ 4	Requires total hands-on assistance and does not physically participate

Comments:	

BATHING OR SHOWERING

Washing body (e.g., bath, shower, sponge bath, or bed bath) includes shampooing hair

☐ 0	Completes the task independently
☐ 1	Requires verbal prompts for washing and drying or help with drawing water, checking temperature
☐ 2	Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g.

	shampooing.)
☐ 3	Requires hands-on assistance during entire bathing process but can physically participate
☐ 4	Requires total hands on assistance and does not physically participate

Comments:	

FOOD PREPARATION

Preparation of simple meals, such as sandwiches, cold cereal, frozen dinners, eggs. Rate the item independent of the heating sources used (e.g., microwave, regular oven, stove top – may use only the microwave and still be independent).

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Requires hands-on assistance to initiate/complete the task
☐ 3	Does not perform this task, even when assisted; the task must be done for the person

Comments:	

COMMUNITY MOBILITY

Movement around the neighborhood or community, including accessing buildings, stores, and restaurants, and using any mode of transportation, such as walking, wheelchair, cars, buses, taxis, bicycles.

☐ 0	Moves about the neighborhood or community independently without assistance
☐ 1	Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions
☐ 2	Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions
☐ 3	Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment
☐ 4	Moves about the neighborhood or community only with accompaniment

Comments:	

Customer Name

Person ID

TOILETING

Involves initiating and caring for those bodily functions involving bowel and bladder control. NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

☐ 0	Completes the task independently
☐ 1	Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
☐ 2	Can indicate the need for toileting, but requires hands-on assist to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet)
☐ 3	Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assist to complete/perform the task
☐ 4	Does not perform nor indicate the need for toileting and requires total caregiver intervention

Comments:	

If bladder accidents occur, how frequently? Times per ☐ Day ☐ Month ☐ Year

Customer Name Person ID

B. COMMUNICATION/COGNITIVE DOMAIN

EXPRESSIVE VERBAL COMMUNICATION

Ability to communicate thoughts verbally with words or sounds.

☐	0	Carries on a complex or detailed conversation
☐	1	Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
☐	2	Uses simple two-word phrases (e.g., “I go,” “give me”)
☐	3	Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities
☐	4	Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts
☐	5	Makes no sounds which are for communication; may babble, cry or laugh

Comments:	

CLARITY OF COMMUNICATION

Ability to speak in a recognizable language or use a formal symbolic substitute, such as American Sign Language or alternate communication system. If has more than one form of communication, score on what is best understood.

☐	0	Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand this individual
☐	1	Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand
☐	2	Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing)
☐	3	Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system
☐	4	Does not communicate using a recognizable language or formal symbolic substitutions

Comments:	

Customer Name Person ID

ASSOCIATING TIME WITH EVENTS AND ACTIONS

Indicate person's sense of time. Note: does NOT have to tell time.

☐ 0	Associates events with specific time (e.g., the concert starts at 7:45)
☐ 1	Associates regular events with specific hour (e.g., dinner is at six, work starts at eight, bedtime is at ten)
☐ 2	Associates regular events with morning, noon, or night (e.g., daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time but knows the sequence of daily events
☐ 3	Does not associate events and actions with time

Comments:	

REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS

Can recall examples of instructions or demonstrations on how to complete a specific task as demonstrated and/or verbally directed. Comments **MUST include examples of tasks assessed.**

☐ 0	Displays memory of instructions or demonstrations without prompting if they are given once
☐ 1	Displays memory of instructions or demonstrations if they are given once and if prompted to recall
☐ 2	Displays memory of instructions or demonstrations if they are repeated three or more times and if prompted to recall
☐ 3	Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations

Comments:	

Customer Name Person ID

C BEHAVIORAL DOMAIN

ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN COMMENTS AND THE INTERVENTION SPECIFIED.

AGGRESSION

Physical attacks on others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. Do NOT include self-injurious behaviors, threatening or property destruction.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional aggression which requires some additional supervision in a few situations and/or verbal redirection
☐ 2	Moderate problem; frequent aggression that requires close supervision and/or physical redirection
☐ 3	Serious problem; constant aggression that requires close supervision and/or constant verbal or physical interruption.
☐ 4	Extremely Urgent problem; has had episode(s) causing injury in the last year, requires close supervision and physical interruption

Comments:	

VERBAL OR PHYSICAL THREATENING

Threatens to do harm to self, others or objects. Do NOT include actual acts of physical aggression or self-injury.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection
☐ 2	Moderate problem; makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection
☐ 3	Serious problem; makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption
☐ 4	Extremely Urgent problem; has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

Comments:	

Customer Name Person ID

SELF-INJURIOUS BEHAVIOR

Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection
☐ 2	Moderate problem; frequent incidents that require close supervision and/or physical redirection
☐ 3	Serious problem; constant incidents; requires close supervision and/or verbal or physical interruption
☐ 4	Extremely Urgent problem; has had episode(s) causing serious injury requiring immediate medical attention in the last year, requires close supervision and physical interruption

Comments:	

RESISTIVENESS/REBELLIOUSNESS

Inappropriately stubborn and or uncooperative, including passive or active obstinate behaviors. Do NOT include difficulties with auditory processing or reasonable expressions of self-advocacy. Do NOT include verbal threatening or acts of physical aggression to self or others.

☐ 0	Problem does not occur or occurs at a level not requiring intervention
☐ 1	Minor problem; occurs occasionally and requires occasional attention, prompting and/or verbal redirection for cooperation
☐ 2	Moderate problem; occurs frequently and requires frequent attention, prompting and/or physical redirection for cooperation
☐ 3	Serious problem; occurs constantly and requires constant attention, prompting and/or physical redirection for cooperation

Comments:	

Customer Name Person ID

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Check appropriate answers)

		A, C, H	Comments	Major Dx
Neurological/Congenital/Developmental Conditions				
1. Cerebral Palsy				
a.	Diplegia	☐ A ☐ C ☐ H		
b.	Hemiplegia	☐ A ☐ C ☐ H		
c.	Quadriplegia	☐ A ☐ C ☐ H		
d.	Paraplegia	☐ A ☐ C ☐ H		
e.	Unspecified Cerebral Palsy	☐ A ☐ C ☐ H		
2. Epilepsy/Seizure Disorder **NOTE:** Indicate **DATE of LAST Seizure** and **FREQUENCY of *EACH TYPE*** of Seizure in Comments.				
a.	Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic.)	☐ A ☐ C ☐ H		
b.	Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	☐ A ☐ C ☐ H		
c.	Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual	☐ A ☐ C ☐ H		
3. Mental Intellectual/Cognitive Disability				
a.	Mild Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
b.	Moderate Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
c.	Severe Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
d.	Profound	☐ A ☐ C ☐ H		

Customer Name

Person ID

	Intellectual/Cognitive Disability			
e.	Unspecified Intellectual/Cognitive Disability	☐ A ☐ C ☐ H		
f.	Borderline Intelligence	☐ A ☐ C ☐ H		
4. Autism				
a.	Autism	☐ A ☐ C ☐ H		
b.	Pervasive Developmental Disorder	☐ A ☐ C ☐ H		
c.	Autistic-Like Behaviors	☐ A ☐ C ☐ H		
5. Attention Deficit Disorder (ADD)				
a.	ADD with Hyperactivity	☐ A ☐ C ☐ H		
b.	ADD without Hyperactivity	☐ A ☐ C ☐ H		
6. Other Neurological / Congenital / Developmental Conditions				
a.	Prematurity	☐ A ☐ C ☐ H		
b.	Fetal Alcohol Syndrome	☐ A ☐ C ☐ H		
c.	Developmental Delays	☐ A ☐ C ☐ H		
d.	Hydrocephaly	☐ A ☐ C ☐ H		
e.	Macrocephaly	☐ A ☐ C ☐ H		
f.	Microcephaly	☐ A ☐ C ☐ H		
g.	Meningitis	☐ A ☐ C ☐ H		
h.	Encephalopathy	☐ A ☐ C ☐ H		
i.	Spina Bifida	☐ A ☐ C ☐ H		
j.	Genetic Anomalies	☐ A ☐ C ☐ H		
k.	Down's Syndrome	☐ A ☐ C ☐ H		
l.	Congenital Anomalies	☐ A ☐ C ☐ H		
m.	Near Drowning	☐ A ☐ C ☐ H		
n.	Head Trauma	☐ A ☐ C ☐ H		
o.	Dementia (Organic Brain Syndrome)	☐ A ☐ C ☐ H		

Customer Name

Person ID

Other Medical Conditions				
7. Hematologic				
a.	Anemia	☐ A ☐ C ☐ H		
b.	HIV Positive	☐ A ☐ C ☐ H		
c.	AIDS	☐ A ☐ C ☐ H		
d.	Leukemia	☐ A ☐ C ☐ H		
e.	Hepatitis	☐ A ☐ C ☐ H		
8. Cardiovascular				
a.	CHF	☐ A ☐ C ☐ H		
b.	Hypertension	☐ A ☐ C ☐ H		
c.	Congenital Anomalies of Heart	☐ A ☐ C ☐ H		
d.	Cardiac Murmurs	☐ A ☐ C ☐ H		
e.	Rheumatic Heart Disease	☐ A ☐ C ☐ H		
9. Musculoskeletal				
a.	Arthritis	☐ A ☐ C ☐ H		
b.	Fracture	☐ A ☐ C ☐ H		
c.	Contracture	☐ A ☐ C ☐ H		
d.	Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)	☐ A ☐ C ☐ H		
e.	Paralysis	☐ A ☐ C ☐ H		
10. Respiratory				
a.	Asthma	☐ A ☐ C ☐ H		
b.	Bronchitis	☐ A ☐ C ☐ H		
c.	Pneumonia	☐ A ☐ C ☐ H		
d.	Respiratory Distress Syndrome	☐ A ☐ C ☐ H		
e.	Bronchopulmonary Dysplasia	☐ A ☐ C ☐ H		
f.	Cystic Fibrosis	☐ A ☐ C ☐ H		
g.	Reactive Airway Disease	☐ A ☐ C ☐ H		

Customer Name

Person ID

h.	Tracheomalacia	☐ A ☐ C ☐ H		
i.	Congenital Pulmonary Problems	☐ A ☐ C ☐ H		
11. Genitourinary				
a.	Urinary Tract Infection	☐ A ☐ C ☐ H		
12. Gastrointestinal				
a.	Constipation	☐ A ☐ C ☐ H		
b.	Ulcers	☐ A ☐ C ☐ H		
c.	Hernia	☐ A ☐ C ☐ H		
d.	Esophagitis	☐ A ☐ C ☐ H		
e.	Gastroesophageal Reflux	☐ A ☐ C ☐ H		
13. EENT				
a.	Blindness	☐ A ☐ C ☐ H		
b.	Cataract	☐ A ☐ C ☐ H		
c.	Hearing Deficit	☐ A ☐ C ☐ H		
d.	Ear Infection	☐ A ☐ C ☐ H		
e.	Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)	☐ A ☐ C ☐ H		
f.	Glaucoma	☐ A ☐ C ☐ H		
14. Metabolic				
a.	Hypothyroidism	☐ A ☐ C ☐ H		
b.	Hyperthyroidism	☐ A ☐ C ☐ H		
c.	Diabetes Mellitus	☐ A ☐ C ☐ H		
d.	Pituitary Problem	☐ A ☐ C ☐ H		
15. Skin Conditions				
a.	Decubitus	☐ A ☐ C ☐ H		
b.	Acne	☐ A ☐ C ☐ H		
16. Psychiatric				
a.	Major Depression	☐ A ☐ C ☐ H		
b.	Bipolar Disorder	☐ A ☐ C ☐ H		
c.	Schizophrenia	☐ A ☐ C ☐ H		

Customer Name Person ID

d.	Behavioral Disorders	☐ A ☐ C ☐ H		
e.	Conduct Disorder	☐ A ☐ C ☐ H		
f.	Alcohol Abuse	☐ A ☐ C ☐ H		
g.	Drug Abuse	☐ A ☐ C ☐ H		

17. Other Diagnoses									Diagnosis
ICD-10	a.							☐ A ☐ C ☐ H	
ICD-10	b.							☐ A ☐ C ☐ H	
ICD-10	c.							☐ A ☐ C ☐ H	
ICD-10	d.							☐ A ☐ C ☐ H	
ICD-10	e.							☐ A ☐ C ☐ H	

	Category	**Condition**	**Diagnosis**
MAJOR DIAGNOSES			

Comments:	

III. Medical Assessment
B. Medications/Treatments

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). Include dosage, frequency, duration, route, form for each medication.

	MEDICATIONS / TREATMENTS / COMMENTS	RX	OTC
1.		☐	☐
2.		☐	☐
3.		☐	☐
4.		☐	☐
5.		☐	☐
6.		☐	☐
7.		☐	☐
8.		☐	☐
9.		☐	☐
10.		☐	☐
11.		☐	☐
12.		☐	☐
13.		☐	☐
14.		☐	☐
15.		☐	☐
16.		☐	☐
17.		☐	☐
18.		☐	☐
19.		☐	☐
20.		☐	☐

Comments:	

C. SERVICES AND TREATMENTS

(Mark appropriate answers) Provide explanation when (N) is circled

			Frequency of Service			
1. Injections/IV	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Intramuscular/Subcutaneous Injections	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

2. Medications/Monitoring	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	☒ R	☐ N	☒ C	☐ D	☐ W	☐ M
b. Drug Administration	☒ R	☐ N	☐ C	☒ D	☐ W	☐ M

Comments:	

3. Dressings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Wound Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Non-Bladder/Bowel Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

4. Feedings	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Tube Feedings	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

5. Bladder/Bowel	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Catheter Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

c. Bowel Dilatation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

			Frequency of Service			
6. Respiratory	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Suctioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Oxygen	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. SVN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Ventilator	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Trach Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Postural Drainage	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Apnea Monitor	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

7. Therapies	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	☒ R	☐ N	☐ C	☐ D	☒ W	☐ M
b. Occupational Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Speech Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Respiratory Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Alcohol/Drug Treatment	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Vocational Rehabilitation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Individual/Group Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
h. Behavioral Modification Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name

Person ID

Comments:	

8. Rehabilitative Nursing	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Teaching/Training Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Bowel/Bladder Retraining	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Turning & Positioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Range of Motion	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Other Rehab Nursing (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

9. Other	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Peritoneal Dialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Hemodialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Chemotherapy/Radiation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Restraints	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Fluid Intake/Output	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Other (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

Customer Name

Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year	
2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	☐ YES ☐ NO
3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	☐ YES ☐ NO

Comments:	

III. Medical Assessment
E. Sensory Functions

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

E. SENSORY FUNCTIONS
(mark appropriate answers)

Impairment	Unable to Assess/ No Impairment	Minimum Impairment	Moderate Impairment	Severe Impairment
1. **Hearing** Ability to perceive sounds	☐ 0	☐ 1	☐ 2	☐ 3
2. **Vision** Ability to perceive objects visually	☐ 0	☐ 1	☐ 2	☐ 3

Comments:	

III. Medical Assessment
F. Summary Evaluation

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Completion Time (minutes)		Travel Time (minutes)	