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**

<table>
<thead>
<tr>
<th>PRIMARY DIAGNOSIS (Dates)</th>
<th>OTHER DIAGNOSIS (Dates)</th>
<th>SURGERY/INFECTIONS (include dates)</th>
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Prognosis of Rehabilitation Potential: ______________________________________________________

Permanent Disability: □ Yes □ No

**MEDICATIONS: Name, Dose, Frequency, and Route**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
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**PAIN ASSESSMENT**

<table>
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<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>(none)</td>
<td>(moderate)</td>
<td>(severe)</td>
<td></td>
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Diagnosis: _______________________ Frequency ______

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)

<table>
<thead>
<tr>
<th>Therapies:</th>
<th>Wound Care:</th>
<th>Pressure Ulcers:</th>
</tr>
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<tbody>
<tr>
<td>PT _____ x’s/wk for _____ /wk’s</td>
<td>site(s) (treatment)</td>
<td>#</td>
</tr>
<tr>
<td>OT _____ x’s/wk for _____ /wk’s</td>
<td></td>
<td>Stage ______ Size _____ cm</td>
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<tr>
<td>ST _____ x’s/wk for r _____ /wk’s</td>
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Respiratory Therapy __________

Oxygen Liters ____ PRN □ Cont □

Chemotherapy/Radiation □

Dialysis □

Bladder & Bowel Training □

Diet __________________________

Foley □ Colostomy □ Urostomy □

Chemotherapy/Radiation □

Tube Feeding _________________
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

Activities of Daily Living (ADL’s)

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<tbody>
<tr>
<td>Bed Mobility</td>
<td>Dressing</td>
<td>Bathing</td>
</tr>
<tr>
<td>Toileting</td>
<td>Eating</td>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Ambulation</td>
<td>Transfer</td>
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Instrumental (ADL’s)

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<tbody>
<tr>
<td>Housekeeping</td>
<td>Meal Prep</td>
<td>Shopping</td>
</tr>
<tr>
<td>Laundry</td>
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</table>

Please circle all that apply:

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 □ Physically Aggressive
□ Resists Care

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: __________________________