GRANDVUE
Charlevoix County Medical Care Facility

Patient: _____

PHYSICIAN'S ADMISSION CHECKLIST
For your attending physician:

In accordance with state and federal guidelines for admission to a skilled nursing facility and Alzheimer's care unit, we need the following information in order to do a proper assessment for placement and care needs.

(WE MUST HAVE THIS INFORMATION!)

(1) CHEST X-RAY REPORT - valid for 90 days prior to admission; report only, film not needed

(2) MEDICAL HISTORY & PHYSICAL - updated in past 3 months

(3) PHYSICIAN'S ORDERS - STATING:
1) Patient's need for 24 hour a day nursing care
2) All diagnoses, including dementia diagnosis
3) Current medications, diet, treatments, allergies, immunizations, therapy treatment needed
4) Signed by the Physician

(4) IMMUNIZATION HISTORY
- Influenza, Pneumonia, Shingles and Tetanus

(5) SCREENING FORMS DCH 3877/3878
(forms are attached with explanation) federal law mandates that this be done prior to admission. Medications and/or diagnosis may require that a DCH 3878 be filled out also.

(6) LAB REPORTS – COPIES OF CURRENT OR TAKEN IN THE LAST YEAR
CBC, urinalysis, TSH, Chem 20 or SMA 12, B12, RPR or VDRL, Folate, *CAT SCAN or MRI, EEG

*if available from records, and required if a client has focal signs, rapid progression of dementia or headaches

1728 S. Peninsula Road * East Jordan, MI 49727 * phone 231-536-2286 * fax 231-536-2476

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Disability/Related Conditions Identification)

Michigan Department of Health and Human Services

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**
☐ **Hospital Exempted Discharge**

SECTION I – Patient, Legal Representative and Agency Information

Patient Name (First, MI, Last)			Date of Birth (MM/DD/YY)	Gender ☐ **Male** ☐ **Female**	
Address (number, street, apt. or lot #)			County of Residence	Social Security Number - -	
City	State	ZIP Code	**Medicaid** Beneficiary ID Number	**Medicare** ID Number	
Does this patient have a court-appointed guardian or other legal representative? ☐ **No** ☐ **Yes** ➔			If Yes, give Name of Legal Representative		
County in which the legal representative was appointed			Address (number, street, apt. number or suite number)		
Legal Representative Telephone Number - -			City	State	ZIP Code
Referring Agency Name			Telephone Number - -	Admission Date (actual or proposed)	
Nursing Facility Name (proposed or actual)			County Name		
Nursing Facility Address (number and street)			City	State	ZIP Code

Sections II and III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

SECTION II – Screening Criteria (All 6 items must be completed.)

1. ☐ No ☐ Yes..... The person has a current diagnoses of **Mental Illness** or **Dementia** (*Circle one*)
2. ☐ No ☐ Yes..... The person has received treatment for **Mental Illness** or **Dementia** (*within the past 24 months) (Circle one)*
3. ☐ No ☐ Yes..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ No ☐ Yes..... There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.
5. ☐ No ☐ Yes..... The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22.
6. ☐ No ☐ Yes..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition. These deficits appear to have manifested before the age of 22.

Note: If you check "Yes" to items 1 and/or 2, circle the word "**Mental Illness**" or "**Dementia**."

Explain any "Yes"

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician signature		Date	Name (type or print)
Address (number, street, apt. number or suite number)			Degree/license
City	State	ZIP Code	Telephone Number - -
AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.			The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION II is "Yes", send **ONE copy** to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility. **Check the appropriate box in the upper right hand corner.**

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

   Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.

3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.

4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets **ALL** 4 of the following conditions:

   a. It is manifested before the person reaches **age 22**.
   b. It is likely to continue indefinitely.
   c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d. It is attributable to:
      - Intellectual Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to Intellectual Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual Disability, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

NOTE: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

MENTAL ILLNESS/INTELLECTUAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

Michigan Department of Health and Human Services
(For Use in Claiming Exemption Only)
Level II Screening

INSTRUCTIONS:

- This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician and signed and dated by a physician's assistant, nurse practitioner or physician.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies.

Patient Name		Date of Birth	
Name of Referring Agency		Referring Agency Telephone Number	
Referring Agency Address (Number, Street, Building, Suite Number, etc.)	City	State	Zip Code

Exemption Criteria

☐ **COMA:** **Yes,** I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA:** **Yes,** I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below.

Yes, I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness.

Yes, I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition.

Specify the type of dementia: _____

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
   - Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.
5. **EITHER:**
   a) Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, **OR**
   b) An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **HOSPITAL EXEMPTED DISCHARGE:**

Yes, I certify that the patient under consideration:

1) is being admitted after a hospital stay, **AND**
2) requires nursing facility services for the condition for which he/she received hospital care, **AND**
3) is likely to require less than 30 days of nursing services.

Physician/Physician's Assistant/Nurse Practitioner Signature	Date	Name (Typed or Printed)
		Telephone Number

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

COPY DISTRIBUTION: **ORIGINAL**- Nursing Facility retains in Patient file
COPY - Attach to form DCH-3877 and send to Local CMHSP
COPY - Patient Copy or Legal Representative

Instructions for Completing Level II Screening

The **DCH-3878** is to be used ONLY when the individual identified on a **DCH-3877, Preadmission Screening (PAS)/Annual Resident Review (ARR)** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, he/she may be admitted or retained at a nursing facility without additional evaluation. However, a completed copy of the **DCH-3878** must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician, **and signed and dated by a physician's assistant, nurse practitioner or physician**.

Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use an **"X"** to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia.

- Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability or a related condition.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type
2. Vascular Dementia
3. Dementia due to Other General Medical Conditions
4. Substance - Induced Persisting Dementia
5. Dementia Not Otherwise Specified

PATIENT NAME: _____ DATE: _____

ADMINISTERED BY: _____

MINI-MENTAL STATE EXAM*

Instructions: Ask all questions in the order listed and score immediately.
Record total number of points.

Maximum Score	Score	
5		Ask the patient to name the year, season, date, day and month. (1 point each)
5		Ask the patient to give his/her whereabouts: State, county, town, facility, floor (1 point each)
3		Ask the patient to repeat three unrelated objects that you name (ball, tree, car). Repeat them and continue to repeat them until all three are learned. (1 point each)
5		Ask the patient to subtract 7 from 100, topping after five subtractions, or spell the word "world" backwards. (1 point for each correct calculation or letter)
3		Ask the patient to repeat the three objects previously named. (1 point each)
2		Display a wrist watch and ask the patient to name it. Repeat this for a pencil. (1 point each)
1		Ask the patient to repeat this phrase: "No ifs, ands, or buts!" (1 point)
3		Have the patient follow a three-point command such as, "Take a paper in your right hand, fold it in half, and put it on the floor." (1 point each)
1		On a blank piece of paper write, "Close your eyes." Ask the patient to read it and do what it says. (1 point)
1		Ask the patient to write a sentence on a blank piece of paper. It must be written spontaneously. Score correctly if it contains a subject and a verb and is sensible. (Correct grammar and punctuation are not necessary.) (1 point)
1		Ask the patient to copy the face of a clock with time 11:40. (1 point)

Total Score: _____ (maximum score = 30)

SCORING: Scores of 23 or less: a high likelihood of dementia
Scores of 25-30: a normal aging or borderline

*adapted from Folstein et al

Grandvue Medical Care Facility

Advanced Directive – Physician Statement

Resident: _____

Based on the evaluation completed on _____, it has been determined that the above referenced Resident is unable to make decisions for him/herself.

Therefore, the undersigned physicians/psychologist is affirming that the resident is incompetent to make decisions and is in agreement to enact the Durable Power of Attorney.

In conjunction with a second physician/psychologist's endorsement, this record activates the Durable Power of Attorney effect with the date of the said endorsement.

Primary Physician: _____ Date: _____

Secondary Physician/Psychologist: _____ Date: _____

****

Patients Rights Michigan Act 312 December 18, 1990
Subsection (8)-Requirement

That the patient's inability to make medical decisions must be determined by the patient's attending physician and another physician or licensed psychologist.

The law requires that the physician or psychologist put the determination in writing, make the written determination a part of the patient's medical record, and review the determination not less than annually.