



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 AND 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

Mental Illness / Intellectual Disability / Related Condition Identification Criteria

Instructions for DCH-3877

The DCH-3877 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, or physician.

Preadmission Screening: The DCH-3877 must be completed by hospitals as part of the discharge planning process or by physicians seeking to admit an individual to a nursing facility from other than an acute care setting. **Check the PAS box.**

Annual Resident Review: The DCH-3877 must be completed by the nursing facility. **Check the ARR box.**

Section II – Screening Criteria – All 6 items on the form 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 physician 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 suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations.
5. **Intellectual Disability / Related Condition:** An individual is considered to have a severe, chronic disability that meets **ALL** four (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 presence of a developmental disability, causal factors, and treatment recommendations.

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

Michigan Department of Community Health
PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)
(Mental Illness / Intellectual Disability/ Related Conditions Identification)

<input type="checkbox"/> PAS
<input type="checkbox"/> ARR
<input type="checkbox"/> Change in Condition

Level I Screening

SECTION I – Patient, Legal Representative, and Agency Information

Patient Name (First, MI, Last)			Date of Birth (M/D/Y)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (Number and Street)			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? <input type="checkbox"/> NO <input type="checkbox"/> 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 & III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or a physician.

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

1. <input type="checkbox"/> NO	<input type="checkbox"/> YES.....	The person has a current diagnosis of	MENTAL ILLNESS	or	DEMENTIA.	<i>(Circle One)</i>
2. <input type="checkbox"/> NO	<input type="checkbox"/> YES.....	The person has received treatment for	MENTAL ILLNESS	or	DEMENTIA	within the past 24 months. <i>(Circle One).</i>
3. <input type="checkbox"/> NO	<input type="checkbox"/> YES.....	The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.				
4. <input type="checkbox"/> NO	<input type="checkbox"/> YES.....	There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment.				
5. <input type="checkbox"/> NO	<input type="checkbox"/> YES.....	The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy.				
6. <input type="checkbox"/> NO	<input type="checkbox"/> 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.				
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 <u>any</u> of the above items are "YES" UNLESS a physician 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 (Typed or Printed)	
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, but, if NOT completed, Medicaid will not reimburse the nursing facility.			The Department of Community Health is an equal opportunity employer, services, and programs provider.		

DISTRIBUTION: If any answer to questions 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.

**MENTAL ILLNESS / INTELLECTUAL DISABILITY / RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)**

Instructions for DCH-3878

- The **DCH-3878** is to be used **ONLY** when the individual identified on a **DCH-3877** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II evaluation. If the individual under consideration meets one of the following exemptions, she/he may be admitted (under preadmission evaluation) or retained (under Annual Resident Review) 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, or physician, **and signed and dated by a 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.

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

Michigan Department of Community Health
MENTAL ILLNESS / INTELLECTUAL DISABILITY / RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

INSTRUCTIONS:

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

Patient Name		Date of Birth	
Name of Referring Agency		Referring Agency Telephone No. () -	
Referring Agency Address (Number, Street, Building, Suite No., 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 a dementia as established by clinical examination and evidence of meeting ALL 5 criteria below and does **NOT** have intellectual disability/related condition or another primary psychiatric diagnosis of mental illness.

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 is:

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

Physician Signature	Date Signed	Name (Typed or Printed)
		Telephone Number () -

AUTHORITY: Title XIX of the Social Security Act COMPLETION: Is voluntary, but, if NOT completed, Medicaid will not reimburse the nursing facility.	The Department of Community Health is an equal opportunity employer, services, and programs provider.
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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

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 the 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: normal aging or borderline

*Adapted from Folstein et al



RESIDENT: _____

GRANDVUE MEDICAL CARE FACILITY
Advanced Directives- Physician Statement

Patient 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.

Attending Physician Statement: _____

Physician Signature

Date

Second Physician or Psychologist Statement: _____

Physician Signature

Date

.....
REVIEW: Annual determination or inability to make medical treatment decisions reviewed.

_____ or _____
Same as Above Change

_____/_____
Attending Physician Date Second Physician/Psychologist Date