



729 S. Norton St. Corunna, MI 48817
Phone: (989) 743-3491 FAX: (989) 743-8681

Admission Request

Completion of this form by the attending physician and its return to the facility is required before a patient will be admitted. Transfer patients from hospitals will have this information supplied by the transferring hospital. Please complete the information as completely as possible and if you are returning the forms by FAX, please include the patient's name on each page. If current information is on file regarding the patient, completion of our form in its entirety may not be necessary. A signed certification of nursing home need, signed by the physician is a requirement. (Please see the bottom of page 3). Please call the facility with any questions.

This portion may be completed by patient's family or responsible party.

Patient Name: _____
 Date Of Birth: _____ Age: ___ Marital Status: _____
 Sex: _____ Religion: _____
 Last Hospital Admission & Discharge Date: _____
 Name Of Hospital: _____
 Responsible Party Name: _____
 Address: _____
 Telephone: _____
 Medicare #: _____ Medicaid #: _____
 Blue Cross/Blue Shield #: _____
 Other Insurance: _____

The Attending Physician Must Complete The Remainder Of The Information.

Diagnosis: _____

Allergies If Any: _____
 Current Treatment: _____
 Diet Order: _____

Drugs:

Name	Dosage	Mode	Frequency	Reason For Med

Rehabilitation Potential: Poor _____ Fair _____ Good _____

Treatments and Other Therapy: E.G. Oxygen, I.V., P.T., Dressings, Tube Feedings, Speech Therapy, Etc.

Check if Present:

Disabilities: Amputation ___ limb(s) ___ Prosthesis ___
Paralysis ___ R ___ L ___ Limb(s) ___
Contractures ___ Site(s) _____

Incontinence: Bladder ___ Catheter ___ Bowel ___
Colostomy ___ Saliva ___ Suctioning needed ___

Impairments: Speech ___ Hearing ___ Vision ___ Sensation ___

Requires use of any adaptive equipment: Wheelchair ___ Cane ___
Crutches ___ Walker ___ Other ___

Activity tolerance limitations: None ___ Med. ___ Sev. ___

Difficulty breathing: _____ Oxygen/Amt. _____

Difficulty swallowing: _____ Suction/Freq. _____

Difficulty eating: Needs help ___ Partially fed ___ Totally fed ___
Tube feeding ___ Gastrostomy ___ I.V. therapy _____

Behavior: Alcoholic ___ Belligerent ___ Suspicious ___ Withdrawn ___ Noisy ___

Mental status: Alert ___ Forgetful ___ Confused ___

Communications:

	YES	NO
Speaks	_____	_____
Writes	_____	_____
Understands Speech	_____	_____
Understands Gestures	_____	_____
Understands English	_____	_____

If Not English, State Language Spoken: _____

Additional Pertinent Information:

**Chest X-Ray Date _____

**Required Test
C.B.C. Date _____ Result _____

Urinalysis Date _____ Result _____

Please enclose, mail, or fax radiologist's and lab reports.

Certification For Extended Nursing Home Care

I certify that continued care in an extended care facility or nursing home is necessary for the following reason(s):

I estimate that the period of E.C.F. inpatient care will be _____ days or indefinite _____.

Continued E.C.F. care is for the same condition for which patient received inpatient hospital services?

Yes _____ No _____

I will _____ not _____ care for this patient after admission to the nursing home.

Physician Signature _____ Date _____

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Last Name	First Name	Primary Care Physician
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MEDICAL HISTORY

(Order of recording)

1. Chief Complaint
2. Present Illness
3. Past History
4. Family History
5. Social History
6. Systemic Review

PHYSICAL EXAMINATION

(Order of recording)

1. General
2. Skin
3. Lymphatic
4. Eyes, Ears, Nose, Throat
5. Mouth
6. Neck
7. Chest
8. Heart-blood vessels
9. Abdomen
10. Genitalia, Vaginal,
Rectal
11. Locomotor
12. Extremities
13. Neurological

Diagnostic Impression

Signature and Date:

<p>ADMITTING PROGRESS NOTE</p>

I certify that NF services are required to be given on an inpatient basis because of this patient's need for skilled or intermediate nursing care.

This patient has been informed of his/her medical condition. YES: _____ NO: _____

If NO: Medical contraindication for informing of medical condition is: _____

Dated: _____ Signature: _____

**PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)
(MENTAL ILLNESS/DEVELOPMENTAL DISABILITY IDENTIFICATION)**
Michigan Department of Social Services

SECTION I - PATIENT, GUARDIAN, AND AGENCY INFORMATION: PAS ARR SIGNIFICANT CHANGE

Patient Name (First, MI, Last)			Date of Birth (M,D,Y)		Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Address (No. & Street)			County		Social Security No.	
City	State	Zip Code	Medicaid No.		Medicare No.	
Does this patient have a court appointed guardian or other designated legal representative? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES ▶			If Yes, Give Name of Legal Representative or Guardian			
County in Which Guardian Appointed			Address (No. & Street)			
Telephone No.			City	State	Zip Code	
Referring Agency Name			Telephone		Admission Date (Proposed or Actual)	
Nursing Facility Name (Proposed or Actual)			County			
Facility Address (No. & Street)			City	State MI	Zip Code	

INSTRUCTIONS:

- SECTIONS II & III of the form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.
- Answer ALL six items below.
- The person screened shall be determined to require a comprehensive LEVEL II OBRA screening if any of items 1 thru 6 have a "YES" indication UNLESS a physician certifies on the DSS-3878 that the person meets one of the exception criteria.
- If you check "Yes" to items 1 and/or 2 in Section II, circle "mental illness" or "dementia."

SECTION II - SCREENING CRITERIA (See copy distribution instructions on reverse side.)

- | | | |
|----|--|---|
| 1. | <input type="checkbox"/> NO <input type="checkbox"/> YES | The person has a current diagnosis of mental illness or dementia (circle one). |
| 2. | <input type="checkbox"/> NO <input type="checkbox"/> YES | The person has received treatment for mental illness or dementia within the past 24 months (circle one). |
| 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 a developmental disability, including but not limited to, mental retardation, 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 suggest that the person may have mental retardation or a related condition. |

Explain any YES:

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)	
		Degree/License	
Address (No. & Street)		Telephone ()	
City	State	Zip Code	

DISTRIBUTION

If any answer to Section II is "YES," send copy to local Community Mental Health board, with copy of DSS-3878 if exception is requested. Nursing facility must retain original in patient record and see that a copy goes to patient or authorized patient representative.

Within the limits of the Medical Assistance Program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs.

AUTHORITY: PA 280 of 1939.
COMPLETION: VOLUNTARY.
CONSEQUENCE FOR NON COMPLETION: Medicaid will not reimburse nursing facility.

MENTAL ILLNESS/DEVELOPMENTAL DISABILITY EXCEPTION CRITERIA CERTIFICATION

(For Use In Claiming Exceptions Only)

Michigan Department of Social Services

INSTRUCTIONS:

- This form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant or physician and signed by a physician.
- The patient being screened shall require a comprehensive LEVEL II screening UNLESS either of the exception criteria below is met and certified by a physician. Indicate which one applies:

Patient Name		Date of Birth	
Name of Referring Agency		Telephone Number ()	
Referring Agency Complete Address	City	State	Zip Code

- COMA:** Yes, I hereby certify the patient under consideration is in a coma.
- DEMENTIA:** Yes, I hereby certify that the patient under consideration has a dementia as established by clinical examination and evidence of meeting ALL five criteria below and does not have a developmental disability.

Specify
Diagnosis:

1. Has demonstrable evidence of impairment in short- 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 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, 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.

- CONVALESCENT CARE:** Yes, I hereby 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 s/he received care, and 3) is likely to require less than 30 days of nursing services. (Attach certification of attending physician.)

Physician Signature	Date Signed	Name (Typed or Printed)
		Telephone Number ()
<small>The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs.</small>		<small>AUTHORITY: PA 280 of 1939. COMPLETION: VOLUNTARY. CONSEQUENCE: Medicaid will not reimburse nursing facility.</small>

GENERAL INSTRUCTIONS

The DSS-3878 is to be used ONLY when a person identified on a DSS-3877 as needing LEVEL II evaluation meets one of the specified exceptions from LEVEL II evaluation. If the individual under consideration meets one of the following exceptions, s/he may be admitted (under preadmission screening) or retained (under annual resident review) at a nursing facility without additional screening. However, a completed copy of the DSS-3878 must be attached to the DSS-3877 and sent to the local community mental health board. The nursing facility must retain the original in the patient record and see that a copy goes to the patient or authorized patient representative.

This form may be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician, but must be certified and signed by a physician. Complete the following information to match the DSS-3877: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use a check mark (✓) to indicate which exception applies to the individual under consideration.

DEMENTIA: Review the five criteria listed under the dementia exception category. Do NOT check this exception unless the individual has a primary diagnosis of dementia and meets all five criteria. Any individual who meets some, but not all five criteria, will be subject to a LEVEL II evaluation. If the person under consideration meets this exception category, please specify the type of dementia.

Dementia diagnoses include the following: Primary Degenerative Dementia of the Alzheimer's Type (senile or presenile onset), Multi-infarct Dementia, Dementia associated with Alcoholism, Senile Dementia NOS (not otherwise specified) or Presenile Dementia NOS.

EXEMPTED HOSPITAL DISCHARGE/CONVALESCENT CARE: Review the three criteria listed under this exception category. Do NOT check this exception unless the individual meets all three categories.