275 Caledonia Dr., Owosso, MI 48867
Phone: (989) 743-3491 FAX: (989) 743-8681

Admission Request

Completion of this form by the attending physician and return of the completed information 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_____

Pleasant View
Shiawassee County Medical Care Facility

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		

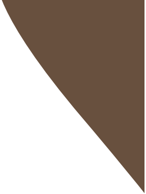
If Not English, State Language Spoken:_____________________

Additional Pertinent Information:

____
____
____
____
____
______

**Chest X-Ray Date_____________Result____
**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__________________

PleasantView
Shiawassee County Medical Care Facility

MEDICAL HISTORY AND PHYSICAL EXAMINATION		
Last Name	First Name	Primary Care Physician

MEDICAL HISTORY

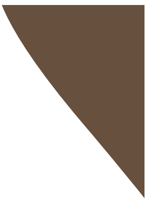
(Order of recording)

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. Genitalla, Vaginal,

    Rectal

11. Locomotor

12. Extremities

13. Neurological

Diagnostic Impression

Signature and Date:

ADMITTING

PROGRESS NOTE

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.

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

Dated:__________________ Signature:____

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 (M/D/Y)	Gender ☐ **Male** ☐ **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? ☐ **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 assistance 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 *(Circle one)* **Mental Illness** or **Dementia** (*within the past 24 months)*
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 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 twenty-two (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 twenty-two (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 or physicians' 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, but, 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 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.

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

Mental Illness / Intellectual Disability / Related Conditions Identification

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. 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** 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. These deficits appear to have manifested before the age of twenty-two (22).

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.