

PreAdmission Screening

Developmentally Disabled/Physically Disabled - Ages 6-11

Case Information			
AHCCCS ID		Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person/App ID:			
Type of PAS	<input type="checkbox"/> Initial <input type="checkbox"/> Reassessment <input type="checkbox"/> Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age			
Birthdate			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Location at time of Assessment			
Telephone Number			

DD Status:	<input type="checkbox"/> Not DD <input type="checkbox"/> Potential DD <input type="checkbox"/> DD in NF <input type="checkbox"/> DD
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Prior Quarter:	Month 1:		Month 2:		Month 3:	
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Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

I. Intake Information

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

Additional Information			
1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	If in an acute care facility, is discharge imminent (within 7 days)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Projected discharge date:		
3.	Ventilator Dependent?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Number of Emergency Room visits in last 6 months(EPD)	0	
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)	0	
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					

I. Intake Information

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

Address					
City		State		Zip Code	
Phone Number(s)					

II. Functional Assessment A. Motor/Independent Living Skills Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

II. FUNCTIONAL ASSESSMENT

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

Circle the number corresponding to the appropriate answer. Give credit for the highest level of skill which is **performed at least 75 percent of the time**. Only give credit for **what the individual actually does**, not for what the individual "can do" or "might be able to do". When a question groups many activities, **rate the individual on his/her ability to complete the task as a whole. Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.**

ROLLING AND SITTING

The Customer's ability to roll and sit independently. "Sitting with support" may include either the physical support of another person or other types of support such as pillows or a specially made chair. Indicate only one answer that best describes the highest level of skill attained.

<input type="checkbox"/> 0	Assumes and maintains sitting position independently
<input type="checkbox"/> 1	Sits without support for at least five (5) minutes
<input type="checkbox"/> 2	Maintains sitting position with minimal support for at least five (5) minutes
<input type="checkbox"/> 3	Rolls from front to back and back to front
<input type="checkbox"/> 4	Rolls from front to back only
<input type="checkbox"/> 5	Rolls from side to side
<input type="checkbox"/> 6	Lifts head and chest using arm support when lying on stomach
<input type="checkbox"/> 7	Lifts head when lying on stomach
<input type="checkbox"/> 8	Does not lift head when lying on stomach

Comments:	
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CRAWLING AND STANDING

"Support" may include the help of another person or mechanical support such as holding on to furniture

<input type="checkbox"/> 0	Stands well alone, balances well for at least five (5) minutes
<input type="checkbox"/> 1	Stands unsteadily alone for at least one (1) minute
<input type="checkbox"/> 2	Stands with support for at least one (1) minute
<input type="checkbox"/> 3	Pulls to a standing position
<input type="checkbox"/> 4	Crawls, creeps, or scoots
<input type="checkbox"/> 5	Does not crawl, creep, or scoot

II. Functional Assessment A. Motor/Independent Living Skills Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

Comments:

AMBULATION

Use of special assistive devices (e.g., canes, walkers, braces) should not affect rating.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Walks well alone for normal distances and on all terrains |
| <input type="checkbox"/> 1 | Walks well alone for a short distance (10 - 20 feet); balances well; distance limitation may be due to terrain. |
| <input type="checkbox"/> 2 | Walks unsteadily alone for a short distance (10 - 20 feet) |
| <input type="checkbox"/> 3 | Walks only with physical assistance from others |
| <input type="checkbox"/> 4 | Does not walk |

Comments:

CLIMBING STAIRS OR RAMPS

Rate use of ramps if individual uses wheelchair or other walking device which is not used on stairs.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Moves up and down stairs or ramps without need for handrail |
| <input type="checkbox"/> 1 | Moves up and down stairs or ramps with handrail independently |
| <input type="checkbox"/> 2 | Moves up and down stairs or ramps with physical assistance |
| <input type="checkbox"/> 3 | Does not move up or down stairs or ramps |

Comments:

WHEELCHAIR MOBILITY

Wheelchair may be motorized or manual.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Wheelchair is not used or moves wheelchair independently |
| <input type="checkbox"/> 1 | Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering) |
| <input type="checkbox"/> 2 | Individual needs some, but not total assistance, in moving wheelchair |
| <input type="checkbox"/> 3 | Needs total assistance for moving wheelchair |

Comments:

II. Functional Assessment A. Motor/Independent Living Skills Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

DRESSING

Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes) |
| <input type="checkbox"/> 2 | Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners) |
| <input type="checkbox"/> 3 | Is not able to actively perform any part of this task but can physically participate |
| <input type="checkbox"/> 4 | Requires total hands-on assistance and does not physically participate |

Comments:

PERSONAL HYGIENE

Those tasks involved in basic grooming, including brushing teeth, washing face and hands, combing or brushing hair, use of deodorant, nail care.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications |
| <input type="checkbox"/> 2 | Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush Or hands on assistance to comb hair) |
| <input type="checkbox"/> 3 | This task must be done for the individual but individual can physically participate |
| <input type="checkbox"/> 4 | Requires total hands-on assistance and does not physically participate |

Comments:

BATHING OR SHOWERING

Washing body (e.g., bath, shower, sponge bath, or bed bath) includes shampooing hair.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Requires verbal prompts for washing and drying or help with drawing water, checking temperature |
| <input type="checkbox"/> 2 | Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g. shampooing.) |
| <input type="checkbox"/> 3 | Requires hands-on assistance during entire bathing process but can physically participate. |
| <input type="checkbox"/> 4 | Requires total hands on assistance and does not physically participate |

II. Functional Assessment A. Motor/Independent Living Skills Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

Comments:

Toileting

Involves initiating and caring for those bodily functions involving bowel and bladder control. NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications |
| <input type="checkbox"/> 2 | Can indicate the need for toileting, but requires hands-on assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet) |
| <input type="checkbox"/> 3 | Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task. |
| <input type="checkbox"/> 4 | Does not perform nor indicate the need for toileting and requires total caregiver intervention. |

Comments:

LEVEL OF BLADDER CONTROL

Rate typical/usual control level.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Complete control (no more than two accidents per year) |
| <input type="checkbox"/> 1 | Some bladder control; accidents occur not as often as seven times per week (day or night) |
| <input type="checkbox"/> 2 | Some bladder control: accidents occur at least seven times per week (day or night) |
| <input type="checkbox"/> 3 | No control |

Comments:

ORIENTATION TO FAMILIAR SETTINGS FAMILIAR TO INDIVIDUAL

(e.g., in home or school setting)

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | No problem in this area; knows way in all areas of familiar settings independently |
| <input type="checkbox"/> 1 | Knows way in part of, but not all of, familiar settings without prompting or physical assistance (e.g., to bathroom, bedroom, or cafeteria) |
| <input type="checkbox"/> 2 | Knows way from room to room within familiar settings with prompting: does not need physical assistance |
| <input type="checkbox"/> 3 | Does not know way from room to room within familiar settings without physical assistance |

II. Functional Assessment
A. Motor/Independent Living Skills
Domain

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 6-11

Customer Name

Person ID

Comments:

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INTERNAL USE ONLY

II. Functional Assessment

B. Communication Domain

PreAdmission Screening

Developmentally Disabled/Physically Disabled

0 – 5 (Under Age 6)

Customer Name

Person ID

B. COMMUNICATION DOMAIN

EXPRESSIVE VERBAL COMMUNICATION

Ability to communicate thoughts verbally with words or sounds.

<input type="checkbox"/> 0	Carries on a complex or detailed conversation
<input type="checkbox"/> 1	Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing)
<input type="checkbox"/> 2	Uses simple two-word phrases (e.g., "I go," "give me")
<input type="checkbox"/> 3	Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities
<input type="checkbox"/> 4	Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts
<input type="checkbox"/> 5	Makes no sounds which are for communication; may babble, cry or laugh

Comments:	
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CLARITY OF COMMUNICATION

Ability to speak in a recognizable language or use a formal symbolic substitute, such as American Sign Language or alternate communication system. If has more than one form of communication, score on what is best understood.

<input type="checkbox"/> 0	Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand this individual.
<input type="checkbox"/> 1	Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand
<input type="checkbox"/> 2	Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing)
<input type="checkbox"/> 3	Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system
<input type="checkbox"/> 4	Does not communicate using a recognizable language or formal symbolic substitutions

Comments:	
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II. Functional Assessment C. Behavioral Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

C. BEHAVIORAL DOMAIN

AGGRESSION

Physical attacks on others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. Do NOT include self-injurious behaviors, threatening or property destruction.

<input type="checkbox"/> 0	Problem does not occur or occurs at a level not requiring intervention
<input type="checkbox"/> 1	Minor problem; occasional aggression which requires some additional supervision in a few situations and/or verbal redirection
<input type="checkbox"/> 2	Moderate problem; frequent aggression that requires close supervision and/or physical redirection
<input type="checkbox"/> 3	Serious problem; constant aggression that requires close supervision and/or constant verbal or physical interruption
<input type="checkbox"/> 4	Extremely Urgent problem; has had episode(s) causing injury in the last year, requires close supervision and physical interruption

Comments:	
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VERBAL OR PHYSICAL THREATENING

Threatens to do harm to self, others or objects. Do NOT Include actual acts of physical aggression or self-injury.

<input type="checkbox"/> 0	Problem does not occur or occurs at a level not requiring intervention
<input type="checkbox"/> 1	Minor problem; makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection
<input type="checkbox"/> 2	Moderate problem; makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection
<input type="checkbox"/> 3	Serious problem; makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption
<input type="checkbox"/> 4	Extremely Urgent problem; has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption

Comments:	
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II. Functional Assessment C. Behavioral Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

SELF-INJURIOUS BEHAVIOR

Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection |
| <input type="checkbox"/> 2 | Moderate problem; frequent incidents that require close supervision and/or physical redirection |
| <input type="checkbox"/> 3 | Serious problem; constant incidents; requires close supervision and/or verbal or physical interruption |
| <input type="checkbox"/> 4 | Extremely Urgent problem; has had episode(s) causing serious injury requiring immediate medical attention in the last <u>year</u> , requires close supervision and physical interruption |

Comments:

RUNNING OR WANDERING AWAY

Leaves situation or environment inappropriately without either notifying or receiving permission from appropriate individuals as would normally be expected.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occasional occurrences which may not pose a safety problem but do require some additional supervision and/or Verbal redirection |
| <input type="checkbox"/> 2 | Moderate problem; frequent occurrences pose minor safety issues to self or others; requires close supervision and/or physical redirection |
| <input type="checkbox"/> 3 | Serious problem; constant occurrences poses safety issues to self or others; requires close supervision and physical redirection |
| <input type="checkbox"/> 4 | Extremely Urgent problem; occurs constantly or poses a very serious threat to the safety of self or others requires close supervision and locked area. |

Comments:

DISRUPTIVE BEHAVIORS

Inappropriately interferes with others, including caregivers, or own activities through behaviors such as: excessive whining or crying, screaming, persistent pestering or teasing, constant demand for attention, repetitious motions. Excessive hyperactivity, repetitive/stereotypic behaviors, or temper tantrums that interfere with others' or own activities should be rated here. Do NOT include verbal threatening or acts of physical aggression to self or others.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occurs occasionally and requires occasional intervention |

II. Functional Assessment
C. Behavioral Domain

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 6-11

Customer Name

Person ID

<input type="checkbox"/> 2	Moderate problem; occurs frequently and requires frequent intervention
<input type="checkbox"/> 3	Serious problem; occurs constantly and requires constant intervention

Comments:	
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III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 6-11

Customer Name

Person ID

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Check appropriate answers)

		<u>A, C, H</u>	<u>Comments</u>	<u>Major Dx</u>
Neurological/Congenital/Developmental Conditions				
1. Cerebral Palsy				
a.	Diplegia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Hemiplegia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Quadriplegia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Paraplegia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Unspecified Cerebral Palsy	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
2. Epilepsy/Seizure Disorder				
NOTE: Indicate DATE of LAST Seizure and FREQUENCY of <i>EACH TYPE</i> of Seizure in Comments.				
a.	Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic.)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis, continual)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
3. Mental Intellectual/Cognitive Disability				
a.	Mild Mental Intellectual/Cognitive Disability	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Moderate Intellectual/Cognitive Disability	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Severe Intellectual/Cognitive Disability	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

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Person ID

d.	Profound Intellectual/Cognitive Disability	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Unspecified Intellectual/Cognitive Disability	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
f.	Borderline Intelligence	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
4. Autism				
a.	Autism	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Pervasive Developmental Disorder	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Autistic-Like Behaviors	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
5. Attention Deficit Disorder (ADD)				
a.	ADD with Hyperactivity	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	ADD without Hyperactivity	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
6. Other Neurological / Congenital / Developmental Conditions				
a.	Prematurity	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Fetal Alcohol Syndrome	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Developmental Delays	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Hydrocephaly	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Macrocephaly	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
f.	Microcephaly	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
g.	Meningitis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
h.	Encephalopathy	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
i.	Spina Bifida	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
j.	Genetic Anomalies	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
k.	Down's Syndrome	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
l.	Congenital Anomalies	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
m.	Near Drowning	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
n.	Head Trauma	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
o.	Dementia (Organic Brain Syndrome)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 6-11

Customer Name

Person ID

Other Medical Conditions				
7. Hematologic				
a.	Anemia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	HIV Positive	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	AIDS	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Leukemia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Hepatitis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
8. Cardiovascular				
a.	CHF	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Hypertension	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Congenital Anomalies of Heart	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Cardiac Murmurs	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Rheumatic Heart Disease	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
9. Musculoskeletal				
a.	Arthritis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Fracture	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Contracture	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Paralysis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
10. Respiratory				
a.	Asthma	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Bronchitis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Pneumonia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Respiratory Distress Syndrome	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Bronchopulmonary Dysplasia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
f.	Cystic Fibrosis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
g.	Reactive Airway Disease	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

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Customer Name

Person ID

h.	Tracheomalacia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
i.	Congenital Pulmonary Problems	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
11. Genitourinary				
a.	Urinary Tract Infection	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
12. Gastrointestinal				
a.	Constipation	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Ulcers	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Hernia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Esophagitis	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Gastroesophageal Reflux	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
13. EENT				
a.	Blindness	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Cataract	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Hearing Deficit	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Ear Infection	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
f.	Glaucoma	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
14. Metabolic				
a.	Hypothyroidism	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Hyperthyroidism	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Diabetes Mellitus	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
d.	Pituitary Problem	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
15. Skin Conditions				
a.	Decubitus	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Acne	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
16. Psychiatric				
a.	Major Depression	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
b.	Bipolar Disorder	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
c.	Schizophrenia	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 6-11

Customer Name

Person ID

d.	Behavioral Disorders	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
e.	Conduct Disorder	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
f.	Alcohol Abuse	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
g.	Drug Abuse	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

17. Other Diagnoses										Diagnosis
ICD-10	a.							<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
ICD-10	b.							<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
ICD-10	c.							<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
ICD-10	d.							<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		
ICD-10	e.							<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H		

	Category	Condition	Diagnosis
MAJOR DIAGNOSES			

Comments:	
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III. Medical Assessment

B. Medications/Treatments

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 6-11

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). Include dosage, frequency, duration, route, form for each medication and average use of major PRN medications.

MEDICATIONS/TREATMENTS/COMMENTS		RX	OTC
1.		<input type="checkbox"/>	<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>
3.		<input type="checkbox"/>	<input type="checkbox"/>
4.		<input type="checkbox"/>	<input type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>
6.		<input type="checkbox"/>	<input type="checkbox"/>
7.		<input type="checkbox"/>	<input type="checkbox"/>
8.		<input type="checkbox"/>	<input type="checkbox"/>
9.		<input type="checkbox"/>	<input type="checkbox"/>
10.		<input type="checkbox"/>	<input type="checkbox"/>
11.		<input type="checkbox"/>	<input type="checkbox"/>
12.		<input type="checkbox"/>	<input type="checkbox"/>
13.		<input type="checkbox"/>	<input type="checkbox"/>
14.		<input type="checkbox"/>	<input type="checkbox"/>
15.		<input type="checkbox"/>	<input type="checkbox"/>
16.		<input type="checkbox"/>	<input type="checkbox"/>
17.		<input type="checkbox"/>	<input type="checkbox"/>
18.		<input type="checkbox"/>	<input type="checkbox"/>
19.		<input type="checkbox"/>	<input type="checkbox"/>
20.		<input type="checkbox"/>	<input type="checkbox"/>

Comments:	
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III. Medical Assessment C. Services and Treatments

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

C. SERVICES AND TREATMENTS

(Mark appropriate answers) Provide explanation when (N) is circled

	Frequency of Service					
	Receives	Needs	Cont.	Daily	Wkly.	Monthly
1. Injections/IV						
a. Intravenous Infusion Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Intramuscular/Subcutaneous Injections	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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	Receives	Needs	Cont.	Daily	Wkly.	Monthly
2. Medications/Monitoring						
a. Drug Regulation	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Drug Administration	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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	Receives	Needs	Cont.	Daily	Wkly.	Monthly
3. Dressings						
a. Decubitus Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Wound Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
c. Non-Bladder/Bowel Ostomy Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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	Receives	Needs	Cont.	Daily	Wkly.	Monthly
4. Feedings						
a. Parenteral Feedings/TPN	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Tube Feedings	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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	Receives	Needs	Cont.	Daily	Wkly.	Monthly
5. Bladder/Bowel						

III. Medical Assessment C. Services and Treatments

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

a. Catheter Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Ostomy Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
c. Bowel Dilatation	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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6. Respiratory	Frequency of Service					
	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Suctioning	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Oxygen	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
c. SVN	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
d. Ventilator	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
e. Trach Care	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
f. Postural Drainage	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
g. Apnea Monitor	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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7. Therapies	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Occupational Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input checked="" type="checkbox"/> W	<input type="checkbox"/> M
c. Speech Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input checked="" type="checkbox"/> W	<input type="checkbox"/> M
d. Respiratory Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
e. Alcohol/Drug Treatment	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
f. Vocational Rehabilitation	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

III. Medical Assessment C. Services and Treatments

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 6-11

Customer Name

Person ID

g. Individual/Group Therapy	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
h. Behavioral Modification Program	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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8. Rehabilitative Nursing	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Teaching/Training Program	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Bowel/Bladder Retraining	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
c. Turning & Positioning	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
d. Range of Motion	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
e. Other Rehab Nursing (specify)	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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9. Other	Receives	Needs	Cont.	Daily	Wkly.	Monthly
a. Peritoneal Dialysis	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
b. Hemodialysis	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
c. Chemotherapy/Radiation	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
d. Restraints	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
e. Fluid Intake/Output	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M
f. Other (specify)	<input type="checkbox"/> R	<input type="checkbox"/> N	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:	
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III. Medical Assessment
D. Medical Stability

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 6-11

Customer Name

Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year	
2. Currently requires direct care staff or caregiver trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Currently requires special diet planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	<input type="checkbox"/> YES <input type="checkbox"/> NO

Comments:	
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III. Medical Assessment
E. Sensory Functions

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 6-11

Customer Name

Person ID

E. SENSORY FUNCTIONS

(mark appropriate answers)

	Unable to Assess/ <u>No Impairment</u>	Minimum <u>Impairment</u>	Moderate <u>Impairment</u>	Severe <u>Impairment</u>
1. Hearing Ability to perceive sounds	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Vision Ability to perceive objects visually	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Comments:	
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III. Medical Assessment
F. Medical Conditions

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 6-11

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?

☐ Yes ☐ No

DATE

Signature

Title

Date

Signature and Title

Title

Date

Completion Time
(minutes)

Travel Time (minutes)