Instructions to the Examining Provider

Your patient is applying for services from the Department of Human Service (DHS). You are requested to complete this form so that the Office of Medical Review (OMR) can determine the Level of Care.

Documentation is required to assist in rendering services that best meet this client’s current needs, either in a Nursing Facility or with Community Services.

What is needed from you to ensure completion of this application:

1. Please complete this PM-1 thoroughly, returning it to the designated Long Term Care Office in a timely manner. All sections must be completed.

2. The PM-1 is essential; other medical information is encouraged, i.e. medication sheets, but not in substitution of this form.

As the examining provider (MD, DO, RNP, PA) you will be assessing your patient’s medical diagnosis, current functional activity, cognitive status and treatments. (Please use the included codes on page 3.)

Thank you in advance of your assistance.

Activities of Daily Living
(See Current Functional Activities)

TRANSFER: ability to move between surfaces. To or from, bed, chair, wheelchair, standing position excluding to/from bath or toilet (with or without assisted device)

AMBULATION: ability to move between locations in the individual’s living environment (with or without assisted device)

BED MOBILITY: ability to reposition body, turning side to side

DRESSING: ability to put on, fasten and take off all items of clothing

BATHING: ability to take a bath, shower, or sponge bath (effectively and thoroughly) and ability to transfer in/out of tub or shower (with or without assistance device)

TOILETING: ability to transfer on/off toilet, cleanses self after elimination, change pad/brief, manage ostomy or catheter, and adjust clothes

EATING: ability to eat and drink using routine or adaptive utensils (this also includes the ability to cut, chew and swallow food)

PERSONAL HYGIENE: ability to comb hair, brush teeth, wash and dry face, hands and perineum

MEDICATION MANAGEMENT: ability to identify and take medications correctly at the right time, route and dose
# Provider Medical Statement

Date _______________________ Date of Last Office Visit _________________________

Applicant Name: ___________________________________________ Date of Birth ________________________  

SS# or MID: _______________________________ Gender (circle): Male       Female  

Address: __________________________________________________________ Apt./Floor: _________________  

City/Town: _____________________________________ State: _______________ Zip Code: ________________  

Current Living Arrangement (circle one):    Lives Alone     Lives with Others     Other: ____________________  

Name of Facility ________________________________________________ Date Admitted: __________________  

## DIAGNOSIS: Medical & Behavioral (including severity of condition) *NO DIAGNOSIS CODES*

<table>
<thead>
<tr>
<th>PRIMARY DIAGNOSIS (Dates)</th>
<th>OTHER DIAGNOSIS (Dates)</th>
<th>SURGERY/INFECTIONS (include dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prognosis of Rehabilitation Potential: ______________________________________________________  

Permanent Disability: □ Yes     □ No  

## MEDICATIONS: Name, Dose, Frequency, and Route

<p>| |</p>
<table>
<thead>
<tr>
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## PAIN ASSESSMENT

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Diagnosis: _______________________ Frequency ___________  

Does pain interfere with individual’s activity or movement? Yes   No  

Is pain relieved by medications/treatment? Yes   No  

## PRESENT TREATMENTS & FREQUENCY

Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)

<table>
<thead>
<tr>
<th>Therapies:</th>
<th>Wound Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT _____ x’s/wk for ____/wk’s</td>
<td>site(s) _______________</td>
</tr>
<tr>
<td>OT _____ x’s/wk for ____/wk’s</td>
<td>(treatment) __________________</td>
</tr>
<tr>
<td>ST _____ x’s/wk for r ____/wk’s</td>
<td>Pressure Ulcers # _______</td>
</tr>
</tbody>
</table>

Respiratory Therapy _______  

Oxygen Liters ____ PRN □ Cont □  

Chemotherapy/Radiation □  

Bladder & Bowel Training □  

Dialysis □  

Bladder □ Yes □ No Frequency _____  

Diet ________________________  

Bowel □ Yes □ No Frequency _____  

Chemotherapy/Radiation □  

Foley □ □ Colostomy □ Urostomy □  

Tube Feeding ______________________
# Current Functional Activity Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>INDEPENDENT: NO TALK, NO TOUCH</td>
</tr>
<tr>
<td></td>
<td>No help or oversight provided to the individual during the activity (with or</td>
</tr>
<tr>
<td></td>
<td>without the use of an assistive device)</td>
</tr>
<tr>
<td>1</td>
<td>SUPERVISION: TALK, NO TOUCH</td>
</tr>
<tr>
<td></td>
<td>Oversight, cueing, and encouragement provided to the individual during the</td>
</tr>
<tr>
<td></td>
<td>activity (with or without the use of an assistive device)</td>
</tr>
<tr>
<td>2</td>
<td>LIMITED ASSISTANCE: TALK AND TOUCH</td>
</tr>
<tr>
<td></td>
<td>Individual highly involved in activity, received physical guided assistance,</td>
</tr>
<tr>
<td></td>
<td>no lifting of any part of the individual</td>
</tr>
<tr>
<td>3</td>
<td>EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT</td>
</tr>
<tr>
<td></td>
<td>Individual performed part of activity but caregiver provides physical</td>
</tr>
<tr>
<td></td>
<td>assistance to lift, move or shift individual</td>
</tr>
<tr>
<td>4</td>
<td>TOTAL DEPENDENCE: ALL ACTION BY CAREGIVER</td>
</tr>
<tr>
<td></td>
<td>Individual does not participate in any part of the activity</td>
</tr>
<tr>
<td>5</td>
<td>ACTIVITY DID NOT OCCUR: NO ACTION</td>
</tr>
<tr>
<td></td>
<td>The activity was not performed by the individual or caregiver</td>
</tr>
</tbody>
</table>

## Activities of Daily Living (ADL’s)

- Bed Mobility
- Dressing
- Bathing
- Toileting
- Eating
- Personal Hygiene
- Medication Management
- Ambulation
- Transfer

## Instrumental (ADL’s)

- Housekeeping
- Meal Prep
- Shopping
- Laundry

Please circle all that apply:
- Cane, Walker, Wheelchair, Bed to Chair, Bedridden, Fall Risk

Can the patient go out unaccompanied?  □ Yes  □ No
Can the patient utilize public transportation independently?  □ Yes  □ No

## COGNITIVE STATUS

Is the patient impaired?  □ Yes  □ No  MMSE Score ______  BIMS Score ______  Date __________

Cognitive Skills for Daily Decision Making (please check one)

- Independent: Decisions consistent/reasonable
- Modified Independence: Some difficulty in new situations only
- Moderately Impaired: Decision poor/cue/supervision required
- Severely Impaired: Never/Rarely makes decisions

Behaviors: Please circle all that apply.

- Disoriented
- Memory Loss
- Resists Care
- Agitated
- Verbally Aggressive
- Physically Aggressive
- Wander
- Other
- Elopement
- Safety Risk

Please include level of severity on the line provided:  1 = Mild  2 = Moderate  3 = Severe

Is patient followed by psych services?  □ Yes  □ No  If yes, where? ________________________________________________________________________________

Has patient been hospitalized for Psychiatric Diagnosis?  □ Yes  □ No  (If yes, give details below.)

Date: __________ Hospital: ____________________________ Diagnosis: _______________________

If nursing home placement is medically necessary, will the patient be likely to return to the community within 6 months?  □ Yes  □ No

Provider’s Name (print) ______________________ Signature: ______________________ Date: __________

(MD, DO, RNP, PA)

For Office Use Only

Social Caseworker: __________________________ District Office: __________________________

Date form sent to Provider: __________________________ Date Received: __________________________