THORNAPPLE MANOR

2700 Nashville Road ~ Hastings, Michigan 49058
(269) 945-2407

ADMISSION MEDICAL HISTORY

Resident Name: _____ ***Age:*** _____

Current Residence Address: _____

City: _____ ***State:*** _____ ***Zip:*** _____

Date of Birth: _____ ***Social Security Number:*** _____

Name of Insurance: _____

Policy I.D. Number: _____ ***Group Number:*** _____

Diet Order: _____

Reason for Admission: _____

History of Present Illness: _____
Additional information may be added on the reverse side.

_____

_____

_____

Current Medications: _____

_____

_____

Allergies: ☐ NKA _____

_____

_____

Past Surgical History:

☐ Appendectomy ☐ Hysterectomy ☐ Other: _____

☐ BSO ☐ ORIF Fracture _____

_

☐ Cataract Surgery ☐ Thyroidectomy _____

☐ Cholecystectomy ☐ T & A _____

☐ Coronary Arterial Bypass

THORNAPPLE MANOR
ADMISSION PHYSICAL EXAMINATION

Patient Name: _____ ***Physician:*** _____

Vital Signs:

Height: _____ Blood Pressure: _____ Respiratory Rate: _____
Weight: _____ Pulse: _____ Pulse Ox: _____

Head:

☐ Normocephalic ☐ Male Pattern Baldness

☐ Seborrhea ☐ Other

EENT:

☐ PERRLA ☐ Fundi Abnormal ☐ Lenticular Cataract

☐ EOM Intact ☐ R ☐ L ☐ R ☐ L

☐ Nystagmus ☐ Exudate(s) ☐ Eyesight Normal

☐ Fundi Benign ☐ A-V Nicking ☐ Eyesight Impaired

☐ Conjunctivae ☐ Hemorrhage(s) ☐ Corrective Lens

☐ Clear ☐ S/P Iridectomy ☐ Blind

☐ Icteric ☐ R ☐ L ☐ R ☐ L

☐ R ☐ L

☐ Nose Clear ☐ Congested ☐ Deviated Septum

☐ Healthy Teeth ☐ Dentures ☐ N-G tube in Place

☐ Poor hygiene ☐ Upper ☐ Lower ☐ Other: _____

☐ Extractions ☐ Full ☐ Partial

☐ Edentulous ☐ Dry Mucous Membranes _____

☐ Deviant uvula ☐ Pharynx clear

Neck:

☐ Normal R.O.M. ☐ S/P Thyroidectomy ☐ Lymphadenopathy

☐ Restricted R.O.M. ☐ Bruit ☐ R Ant ☐ L Ant

☐ Normal ☐ R ☐ L ☐ R Post ☐ L Post

☐ Thyromegaly Grade _____/4

Thorax/Back:

☐ A-P Diameter W.N.L. ☐ Increased A-P Diameter ☐ Tender to Percussion

☐ Normal Contours ☐ Scoliosis Location: _____

☐ Pectus Deformity ☐ Kyphosis _____

Breasts:

☐ Normal Male ☐ S/P Mastectomy ☐ R ☐ L ☐ Discharge ☐ R ☐ L

☐ Normal Female ☐ Tender ☐ R ☐ L ☐ Inverted Nipple ☐ R ☐ L

☐ Asymmetrical ☐ Mass ☐ R ☐ L

☐ Atrophic

Lungs:

☐ Clear A-P. ☐ Reduced Breath Sounds ☐ Anterior ☐ Post

☐ Dull Percussion ☐ Absent Breath Sounds ☐ R.U.L. ☐ L.U.L.

☐ Crackles ☐ Wheezing ☐ R.M.L. ☐ Lingula

☐ Fine ☐ Moist ☐ Rhonchi ☐ R.L.L. ☐ L.L.L.

THORNAPPLE MANOR
ADMISSION PHYSICAL ADMISSION HISTORY

Past Medical History:

☐ Alzheimer's/Dementia ☐ Congestive Heart Failure ☐ M.R.S.A.

☐ Anemia ☐ Coronary Artery Disease ☐ When? _____

☐ Anxiety ☐ Degenerative Joint Disease ☐ Site? _____

☐ C-Diff ☐ Depression ☐ Osteoporosis

☐ When? _____ ☐ Diabetes Mellitus ☐ Parkinsonism

☐ Cancer ☐ Hyperlipidemia ☐ Other: _____

☐ Primary? _____ ☐ Hypertension _____

☐ Metastatic? _____ ☐ Malnutrition

Review of Systems:

HEENT

☐ W.N.L. ☐ Dry Mouth ☐ Edentulous

☐ Deaf
☐ R ☐ L
☐ Congested Nose
☐ Corrective Lens

☐ Sight Impaired
☐ Blind
☐ R ☐ L

☐ Other: _____
_____

Neck

☐ W.N.L.
☐ Impaired R.O.M.

☐ Thyroid Problem
☐ Hypo-
☐ Hyper-
☐ Enlarged

☐ Other: _____
_____

Cardiopulmonary

☐ W.N.L.
☐ Atrophic
☐ Cough
☐ Chest Pain

☐ Dyspnea or Exertion
☐ Orthopnea
☐ Palpitations
☐ Pedal Edema

☐ P.N.A
☐ Other: _____
_____

Gastrointestinal

☐ W.N.L.
☐ Abdominal Pain
☐ Constipation

☐ Diarrhea
☐ Dysphagia

☐ Nausea
☐ Vomiting

Genitourinary

☐ W.N.L.
☐ Chronic Catheter
☐ Urethral
☐ Suprapubic

☐ Dysuria
☐ Dribbling
☐ Hermaturia
☐ Unable to Void

☐ Vaginal Bleeding
☐ Other: _____
_____

Neuromuscular

☐ W.N.L.
☐ Contracture
☐ Edema
☐ RLE ☐ LLE
☐ Joint Stiffness

☐ Muscle Wasting
☐ Paralysis
☐ RUE ☐ LUE
☐ RLE ☐ LLE
☐ Tremor

☐ Vascular
☐ Weakness
☐ Other: _____
_____

THORNAPPLE MANOR
ADMISSION PHYSICAL ADMISSION HISTORY (con't)

Heart:

- ☐ W.N.L. Rate and Rhythm
- ☐ Irregular Rhythm
- ☐ Rate Abnormal
  - ☐ Tachy ☐ Brady
- ☐ Parasternal Lift
- ☐ S1 and S2 W.N.L.
- ☐ Abnormal Heart Sounds
  - ☐ S3 ☐ S4
  - ☐ Rub ☐ Click
- ☐ Thrill
- ☐ Murmur
- ☐ Systolic
- ☐ Diastolic
- ☐ Grade ____/6

Abdomen:

Bowel Sounds-

- ☐ Normal
- ☐ Increased
- ☐ Decreased
- ☐ Hernia ☐ R ☐ L
- ☐ Hydrocoele
- ☐ Mass (describe) _____
  _____
- ☐ Tenderness (describe) _____
  _____
- ☐ Scars (describe) _____
  _____
- ☐ Hernia (describe) _____
  _____

Male Genital:

- ☐ Normal Genitalia
- ☐ Circumcised
- ☐ Uncircumcised
- ☐ Hernia ☐ R ☐ L
- ☐ Tender
- ☐ Hydrocele
- ☐ Varicocele
- ☐ Epididymis
- ☐ Swollen
- ☐ Indwelling Catheter
- ☐ Mass

  Describe: _____
  _____

Female Genital:

- ☐ Normal Genitalia
- ☐ Vagina W.N.L.
- ☐ Uterus W.N.L.
- ☐ Adnexa W.N.L.
- ☐ Cervix W.N.L.
- ☐ Enterocele
- ☐ Pap Smear Done
- ☐ Cystocele
- ☐ Rectocele
- ☐ Enlarged Uterus
- ☐ Adnexal Mass
  - ☐ R ☐ L
- ☐ Contracted Vagina
- ☐ Atrophic Vaginitis
- ☐ S/P Hysterectomy
- ☐ Other: _____
  _____

Rectal:

- ☐ Normal Sphincter
- ☐ Anal Stenosis
- ☐ Anal Laxity
- ☐ Stool
  - ☐ Hard
  - ☐ Soft

MALE ONLY

- ☐ Normal Prostate
- ☐ B.P.H.

☐ Hemorrhoids
- ☐ External
- ☐ Internal

☐ Normal Sphincter

☐ None
☐ Guaiac Negative
☐ Guaiac Positive

☐ Tender Prostate
☐ Nodular
☐ Hard

Extremities:

☐ Symmetrical
☐ Asymmetrical
☐ Lymphadenopathy
☐ Edema ☐ R.L.E. ☐ L.L.E.
degree _____ _____
☐ Hallux Valgus ☐ R ☐ L
☐ Other: _____
_____

☐ Abnormal Pulses
- ☐ Brachial ☐ R ☐ L
- ☐ Radial ☐ R ☐ L
- ☐ Femoral ☐ R ☐ L
- ☐ Popliteal ☐ R ☐ L
- ☐ Dorsalis ☐ R ☐ L
- ☐ Brachial

☐ Onychogryphosis
☐ Hammer Toes ☐ R ☐ L
☐ Varicose Veins ☐ R ☐ L
☐ S/P Amputation
- ☐ RLE ☐ LLE
- ☐ AK ☐ BK
- ☐ Other: _____

THORNAPPLE MANOR
ADMISSION PHYSICAL ADMISSION HISTORY (con't)

Neurological:

☐ CNII-XII W.N.L.
☐ O. Sensory Deficit
- ☐ Babinski W.N.L.

☐ Vibratory intact

☐ Abnormal C.N.
☐ O Motor Deficit
☐ D.T.R.S. brisk/symmetrical
☐ Abnormal D.T.R.

☐ Paresis/Plegia
☐ Hemi- ☐ R ☐ L
☐ Para -
☐ Quad.

Skin:

☐ No lesions
☐ Other:
_____
_____
__

Social History:

☐ Single
☐ Alcohol Use ☐ Yes ☐ No
☐ Living Independently Prior to Admission

☐ Married
☐ Tobacco Use ☐ Yes ☐ No
☐ Living with Family
☐ Other Living Arrangements: ___
_____

☐ Widowed
☐ Street Drugs ☐ Yes ☐ No
☐ Living in A.F.C.

Mental Status:

W.N.L.

☐ Memory ☐ Other: _____

☐ Orientation _____

☐ Judgement _____

☐ Intelligence

Clinical Impression:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician's Name: _____ ***Date:*** _____

Michigan Department of Community Health

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

(Mental Illness / Intellectual Disability/ Related Conditions Identification)

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**

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 & 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. ☐ NO ☐ YES ..... The person has a current diagnosis of **MENTAL ILLNESS** or **DEMENTIA**. ***(Circle One)***
2. ☐ NO ☐ YES ..... The person has received treatment for **MENTAL ILLNESS** or **DEMENTIA** within the past 24 months. ***(Circle One).***
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.
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.
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.

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 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)
			Degree / License
Address (Number, Street, Apt. Number or Suite Number)			
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 providea copy to the patient or legal representative.

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 Health and Human Services

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 Health and Human Services is an equal opportunity employer, services, and programs provider.

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

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