

**Medical Review/Prolonged Care Assessment**

	IC-ICF/DD – ICF/DD-H	Semi-Annual	Annual
Name	Sex	Male	Female
Case Number	Birth Date		
Admission Date	Attending Physician		
Present Status Other	NH	IC	RC
Facility			
Address (number, street)			
City		Zip Code	
Diagnoses			
Medications			
Lab Work			
Diet			
1) Is the patient involved in school and is treatment plan coordinated with the school? Yes      No			
2) Is the patient involved in daily planned activities or any type of learning experience? Yes      No			
3) Is patient and staff interaction ongoing? Yes      No			
4) Is there <i>any</i> potential? Yes      No			

5) Is Plan of Care current?

Before Admission    After Admission    Yes    No

6) Are individual goals reviewed and/or met/updated?

Yes    No

7) Are quarterly notes written timely?

Yes    No

8) Are psychological evaluations done?

Yes    No

9) Is there QMRP input in the chart and/or whole interdisciplinary team?

Yes    No

Every 90 days?

Yes    No

Dates of Visits

Interviewer

**Recommendations**

Chart Review

Skilled Nursing

ICF

RCF

ICF/DD

ICF/DD/H

**Instructions: For ICF/DD/H—Complete all appropriate boxes; others—exclude ICF/DD/H only**

Patient Name		Date of Birth
Sex	Male      Female	Medi-Cal ID Number
Admission Date		Room Number
Facility Name		Phone Number
Facility Address (number, street)		
City		Zip Code
Signature of Person Completing Form	Title	Current Diagnosis
Patient's Condition Now	Rehabilitation Potential	
Stable	Good	
Unstable	Fair	
Terminal	Poor	

**Complete this section for ICF/DD/H only**

<p>Program Provided</p> <p><i>Frequency: 1—Once a day; 2—BID; 3—TID; 4—2; or more per week; 5—weekly</i></p> <p>Range of motion</p> <p>Preventive/corrective positioning</p> <p>Ambulation skills</p> <p>Transfer skills</p> <p>Grooming/dressing skills</p> <p>Mental stimulation</p> <p>Communication skills</p> <p>Bladder retraining</p> <p>Bowel retraining</p> <p>Feeding skills</p> <p>Social behavior</p> <p>Aggression</p> <p>Self-injurious</p> <p>Smearing</p> <p>Destruction of property</p> <p>Running or wandering away</p> <p>Temper tantrums or emotional outbursts</p>	<p>Plan of Care</p> <p>Individual goals are met and updated?</p> <p>Yes</p> <p>No</p> <p>Is the plan of care complete?</p> <p>Yes</p> <p>No</p>
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<p style="text-align: center;"><b>Degree of Retardation</b></p> <p>Mild Moderate Severe Profound</p>	<p style="text-align: center;"><b>Activities of Daily Living</b></p> <p>Mark either—Independent (1), Assistance with mechanical device (A1) Assistance with a person (A) Assistance by person and device (A3) or Total Dependent (D) Walking Transferring Wheeling Bathing Dressing Grooming Toileting</p>
<p style="text-align: center;"><b>Visual</b></p> <p>No apparent handicap Correctable vision w/glasses Severe visual impairment Legally or totally blind</p>	<p style="text-align: center;"><b>Auditory</b></p> <p>No apparent hearing problem Mild hearing problem Wears hearing aid Deafness, corrected by aid Deafness, not corrected</p>
<p style="text-align: center;"><b>Mental and Behavioral Status</b></p> <p>Receiving psychiatric care x3 Alert and oriented x3 Disoriented Confused Wanderer Noisy, yells/agitated Aggressive Combative Other antisocial behavior Withdrawn Comatose Follows simple instructions</p>	<p style="text-align: center;"><b>Communication</b></p> <p>Able to make needs known Speaks no English Can write, not speak Cannot speak or write, but seems to comprehend Aphasic, partial Aphasic, complete</p>
<p style="text-align: center;"><b>Wound Care—Dressings</b></p> <p>Dry sterile dressing Open, draining Sterile/medicated dressing</p>	<p style="text-align: center;"><b>Diabetic Care</b></p> <p>Inability to manage diabetic condition Well-regulated by diet only Well-regulated with medication Uncontrolled Urine testing</p>
<p style="text-align: center;"><b>Rehabilitation and M.D. Orders</b></p> <p>Physical therapy Occupational therapy Speech therapy</p>	<p style="text-align: center;"><b>Rehabilitative Nursing Program</b></p>

Other Special Needs/Problems	Bowel Control
Amputee—location Braces/cast Seizures Paralysis/area Joint motion/pain/swelling Inhalation/oxygen therapy Tracheostomy care Suctioning Multiple injections or IVs Fluid retention Isolation techniques Contractures	Occasionally involuntary Involuntary Colostomy/Ileostomy Self-care Bladder
Bladder Control	Feeding
Occasionally incontinent Incontinent Catheter Bowel-Bladder Training—Date	Feeding program date Feeds self with assistive device Needs partial help in feeding Needs to be fed N-G tube Gastrostomy Parenteral Supplemental feedings
Current Medications	Decubitus Ulcer
Antibiotics Cardiac drugs Diuretics Anticoagulants Chemotherapy Insulin Tranquilizers Hypnotics Narcotics Oral hypoglycemic	None or healed Stage I—red/inflamed area Stage II—superficial skin break w/red surrounding Stage III Stage IV

**DO NOT COMPLETE BELOW THIS LINE—STATE USE ONLY**

General Appearance of Patient			Physician's progress notes timely? Yes No Medications reviewed and signed timely? Yes No Date of tuberculin testing, quantiFERON test, or chest X-ray:		
1. Clean	Yes	No			
2. Hair clean and neat	Yes	No			
3. Shaved	Yes	No			
4. Fingernails clean/trimmed	Yes	No			
5. Toenails clean/trimmed	Yes	No			
6. Dressed appropriately	Yes	No			
7. Out of bed	Yes	No			
8. Restrained	Yes	No			
9. Transportation	Yes	No			
10. Equipment	Yes	No			
Date of last physical			Notes:		
Significant laboratory results					
Chart review Yes No		Patient interview Yes No		Prolonged care Yes No	
Reviewer's signature			Date		