OBRA PREADMISSION SCREENING REPORT

Level II Summary

Date of Review:

| I. Individual’s Information |
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| Name:        |  Social Security #: XXX-XX-      |
| Address:       |
| DOB:       | Supported by DDS [ ]  Yes [ ]  No  | DDS#:       |
|  | DDS Class Member [ ]  Yes [ ]  No |  |
| Hospital:       |
| Skilled Nursing Facility:       |

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| **II. Reason for Referral** |
| [ ]  Change in health status  | [ ]  Family no longer able to provide care  |
| [ ]  Convalescent/Rehabilitation  | [ ]  Respite |
| [ ]  Other (specify):       |

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| **III. Legal Representative/Guardian/Family/Contact Person** |
| Name:       |
| Address:      |
| Phone:       |

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| **IV. Sources of Information** |
| [ ]  DSS/DSS-contracted agency referral  | [ ]  Hospital:        |
| [ ]  Individual:        | [ ]  Nursing Facility:        |
| [ ]  Family:       | [ ]  DDS Case Manager:       |
| [ ]  Agency Nurse:       | [ ]  Other:       |

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| **V.** **Preadmission Living Situation** |
| [ ]  Community Living Arrangement (CLA)  | [ ]  Continuous Residential Supports (CRS) Home | [ ]  Individualized Home Supports (IHS) |
| [ ]  Community Companion Home (CCH) | [ ]  Family Home[ ]  Own Home | [ ]  Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) |
| Provider/Agency:        | [ ]  Other:       |

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| **VI. Developmental History** |
| [ ]  Documentation received by DDS indicates this individual has intellectual disability (ID) in the range of: [ ]  Mild ID [ ]  Moderate ID [ ]  Severe ID [ ]  Profound ID |
| IQ testing results prior to age 18:       Unknown [ ]  |
| Developmental milestones: WNL [ ]  Delayed [ ]  Unknown [ ]  |
|  |
| [ ]  Documentation received by DDS indicates this individual has a developmental disability (DD) |
| Developmental disability prior to age 22: [ ]  Yes [ ]  No Specify:       |
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| Individual’s Diagnoses:       |
| Medications:       |
| Allergies:       |
| Other pertinent information:       |

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| **VII. Developmental Disability Functional Profile Areas** |
| **Learning/Self-Direction/Independent Living** |
|  | ID prior to age 18, DD prior to age 22 | Current level of functioning |
|  | If documentation of ID is present in the DDS file, only complete current level of functioning in Functional Profile Area | Based on an interview with the individual, legal representative(s), SNF staff |
|  |  |  |
|  | Yes | No | Unknown | Yes | No | Unknown |
| Special Education Services | [ ]  | [ ]  | [ ]  |  |
| Completed grade school | [ ]  | [ ]  | [ ]  |
| Completed high school | [ ]  | [ ]  | [ ]  |
| Taking or completed college courses | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously married | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously employed | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously had a driver’s license | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously resided in own apartment or own home | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Initiates phone calls | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Knows value of money | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously managed/had a bank account | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Oriented to current date, time and location | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Independently schedules medical/dental appointments  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Able to self-administer medications | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Currently or previously shopped for food and clothing independently  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other pertinent information:       |

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| **Self-Care** |
|  | ID prior to age 18,DD prior to age 22 | Current level of functioning |
|  | Independent | Needs Assistance | Total Care | Independent | Needs Assistance | Total Care |
| Dresses self completely | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Dresses appropriately for weather conditions  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Uses silverware appropriately | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Bathes or showers | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Cares for all toileting needs | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Brushes teeth | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Makes own bed | [ ]  | [ ]  | [ ]  |  |
| Does laundry | [ ]  | [ ]  | [ ]  |
| Other pertinent information:       |

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| **Understanding Language/Communication** |
|  | ID prior to age 18,DD prior to age 22 | Current level of functioning |
|  | Yes | No | Unknown | Yes | No | Unknown |
| Able to read | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Able to write | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Tells or retells stories or jokes | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Asks “what, why, when” questions | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Can listen to a story for at least 5 minutes | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Uses gestures to communicate | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Uses sign language to communicate | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Use of adaptive device(s) to communicate | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Uses eye movement or other nonverbal communication | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other pertinent information:       |

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| **Mobility** |
|  | ID prior to age 18,DD prior to age 22 | Current level of functioning |
|  | Yes | No | Unknown | Yes | No | Unknown |
| Walks unassisted  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   | [ ]  |
| Is able to walk only on level ground | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   | [ ]  |
| Uses a walker or a cane  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   | [ ]  |
| Uses a wheelchair | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Spends most of the time in bed | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other pertinent information:       |

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| **VIII. Health Information Review** |
| [ ]  Medical information including current diagnoses, medications and medication allergies can be found on the Health Screen/Interagency Referral document or the OBRA preadmission referral packet received from DSS or a DSS-contracted agency.  |
| [ ]  If there is an alternative document or source for the individual’s medical information, please specify:       |
| Advance Directives [ ]  Yes [ ]  No Code Status:       |

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| **IX. Identified Safety Precautions**  |
| [ ]  Swallowing Risk due to:       |
| [ ]  Severe limitations in mobility requiring:        |
| [ ]  Severe seizure disorder requiring:       |
| [ ]  Other condition(s) requiring safety precautions (specify):        |
| [ ]  Unknown  |

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| **X. Behavioral Needs** |  |
| [ ]  Wandering  | [ ]  Unsafe/unhealthy hygiene habits |
| [ ]  Impaired judgment with threats to health/safety | [ ]  Abusive/Assaultive (verbal or physical)  |
| [ ]  Other:        | [ ]  Unknown |

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| **XI. Nursing Needs** |
| [ ]  Assess and monitor medical status:       |
| [ ]  Monitor medication effectiveness and possible side effects:       |
| [ ]  Monitor prescribed diet:       |
| [ ]  Other:       |

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| **XII. Therapy Services** |
| [ ]  Occupational:       |
| [ ]  Physical:       |
| [ ]  Respiratory:       |
| [ ]  Other:        |

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| **XIII. Vocational Needs** |
| Current vocational placement or day program:       |

**XIV. Conclusion**

**Intellectual Disability Status:**

[ ]  Intellectual disability **is**  substantiated prior to age 18.

[ ]  Intellectual disability **is not** substantiated prior to age 18.

**Developmental Disability Status:**

[ ]  Developmental disability **is**  substantiated prior to age 22.

[ ]  Developmental disability **is not** substantiated prior to age 22.

**Placement:**

[ ]  Individual is eligible for short term nursing facility placement with goal to return to community.

[ ]  Individual is eligible for long term nursing facility placement.

[ ]  Individual does not meet eligibility criteria for nursing facility placement.

**Service Needs:**

**[ ]**  No specialized service needs are present at this time.

[ ]  The following Specialized Service needs have been identified:

[ ]  Behavior modification/management

[ ]  Out-of-facility recreational opportunities beyond that provided by nursing facilities

[ ]  Vocational or day programming services

[ ]  Adaptive equipment needed (specify):

[ ]  Habilitation services (e.g., physical therapy, speech therapy, occupational therapy etc.)

[ ]  Case management to determine specialized service needs

[ ]  Other (specify):

[ ]  Specialized service needs can be met by the nursing facility.

[ ]  Specialized service needs can be met with the assistance of DDS in the nursing facility.

**Recommendations and level of support needed to return to the community:**

***Please contact the individual’s DDS Case Manager for Care Plan Conferences, changes in condition, hospitalizations, need for change in code status, or upon the individual’s death.***

Case Manager:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DDS OBRA/Long-Term Care Nurse:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      \_\_\_\_\_\_\_\_