



### I. MEDICAL STATUS

Medical History	For each condition circle the following code: 1-if not present, 2-if present, 3-if present and interferes with living, 4-past history								
A. Alcoholism	1	2	3	4	L. Heart Disease	1	2	3	4
B. Alzheimer/Dementia	1	2	3	4	M. High Blood Pressure	1	2	3	4
C. Amputation	1	2	3	4	N. Kidney Disease	1	2	3	4
D. Arthritis (Rheumatism)	1	2	3	4	O. Mental Illness	1	2	3	4
E. Anemia	1	2	3	4	P. Paralysis	1	2	3	4
F. Cancer	1	2	3	4	Q. Parkinson's Disease	1	2	3	4
G. CVA (stroke)	1	2	3	4	R. Respiratory: Asthma/ Bronch/Emphysema	1	2	3	4
H. Diabetes	1	2	3	4	S. Skeletal Trauma	1	2	3	4
I. Epilepsy/Seizure Disorder	1	2	3	4	T. Skin Disease/Ulcers	1	2	3	4
J. Gastric Disease	1	2	3	4	U. Thyroid Disease	1	2	3	4
K. Glaucoma/Cataract	1	2	3	4	W. Nutritional Deficit	1	2	3	4
V. Tuberculosis	1	2	3	4					

COMMENTS: \_\_\_\_\_

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Name and Location of Client's Physician(s)

Name	Location	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Devices	For each device circle the following code: 1-if does not need, 2-has and uses, 3-has, does not use, 4-needs, does not have								
A. Artificial Limb	1	2	3	4	E. Wheelchair	1	2	3	4
B. Walker	1	2	3	4	F. Hospital Bed	1	2	3	4
C. Cane	1	2	3	4	G. Other (specify)	1	2	3	4
D. Bedside Commode	1	2	3	4					

## Neurological Systems

### Comments

Motor Functioning	_____
	_____
	_____
Sensory Functioning	_____
	_____
	_____
Gait	_____
	_____
	_____
Deep Tendon Reflexes	_____
	_____
	_____
Cranial Nerves	_____
	_____
	_____
Abnormal Reflexes	_____
	_____
	_____

INDICATE NUMBER OF TIMES IN THE LAST YEAR THE CLIENT HAS BEEN TAKEN TO:

	Number of Times	Reason
1. Hospital/Emergency Room		
2. Nursing Home		
3. Physician		

If the history and physical examination was not performed by a physician,  
Then a physician's countersignature is required.

\_\_\_\_\_  
Physician's Countersignature

\_\_\_\_\_  
Date



## II. PSYCHOSOCIAL/FUNCTION EVALUATION

### Usual Living Arrangements

	Alone	Spouse	Other
Home/Apartment	_____	_____	_____
Rental Room	_____	_____	_____
Boarding Home	_____	_____	_____
Health Care Facility _____	(Name of Facility)		

Other: \_\_\_\_\_  
(Please Specify)

### Functional Evaluation

The purpose of this list is to assure that all necessary components of functional status have been evaluated. Using the scale, circle the number which indicates the level of ability to self-monitor or perform the listed functional activities. For non-independent functioning indicate who (friend, neighbor, volunteer, family member, health care professional or other) assists with or performs activity. Identify other activities as appropriate.

Activity	Level of Ability				Who provides assistance
1. Health Status: Is able to recognize well-being and/or illness.	1	2	3	4	_____
2. Medical Treatment/Compliance: Scheduling and administering of medical treatment—is able to obtain needed medical attention and follow through on physician’s recommendations, including prescribed medications.	1	2	3	4	_____
3. Nutritional Status: Is able to obtain and prepare food independently, eats well-balanced meals, maintains weight.	1	2	3	4	_____
4. Finances: Is able to budget, perform banking transactions, pay taxes.	1	2	3	4	_____
5. Dressing: Is able to clothe self in an appropriate manner.	1	2	3	4	_____
6. Other _____	1	2	3	4	_____
_____	1	2	3	4	_____
_____	1	2	3	4	_____

**SCALE:**

- |  |  |  |   |
|--|--|--|---|
| <p>1. Independent: Able to perform activity independently; no assistance or oversight needed or provided</p> | <p>2. Supervision: Able to perform activities with encouragement or oversight, requires regular but infrequent contact with others (1-3 times per week).</p> | <p>3. Assistance: Able to perform activity only with physical or cognitive aid from others, requires frequent contact with supportive services (3-5 times per week).</p> | <p>4. Dependent: Unable to perform activity; activity must be performed by others, requires daily (6-7 times per week) Support.</p> |
|--|--|--|---|

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### III. PSYCHIATRIC EVALUATION

**DIRECTIONS:** The purpose of this checklist is to assure that all relevant clinical areas have been assessed during the psychiatric evaluation. To indicate that each area has been assessed, place a check next to the item on the list. A space is provided for a brief summary of clinical findings which should stress those abnormal findings which would lead to a recommendation for specialized services (refer to the definition in the Procedures Manual). Attach all relevant documentation.

1.  Review of documentation related to psychiatric history  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2.  Evaluation of intellectual functioning, memory and orientation  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3.  Evaluation of current attitudes and overt behaviors  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Evaluation of affect and mood  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Evaluation of suicidal and homicidal ideation  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Evaluation of reality testing (presence and content of delusions and hallucinations)  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Identification of psychiatric diagnosis which require specialized services as defined by HCFA (refer to Procedure Manual)  
Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specify diagnosis and recommended treatment(s) (whether or not specialized services is recommended)**

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**LEVEL II ASSESSMENT FINDINGS**

1. Confirmation of Diagnosis

No MI Diagnosis.

Diagnosis confirmed. \_\_\_\_\_  
Diagnosis

2. Specialized Services

Specialized services not indicated

Specialized services recommended (see attached Plan of Care)

3. Authorization

\_\_\_\_\_  
Signature of Person Completing Assessment

\_\_\_\_\_  
Date

Comments: \_\_\_\_\_

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