

**ADULT RESIDENTIAL LICENSING
PERSONAL CARE HOME PREADMISSION SCREENING
55 Pa.Code § 2600.224 and § 2600.231**

(To be completed by the referring human service agency, the PCH administrator or designated PCH staff member within 30 days prior to admission.)

Name:	Birthdate:
Address:	Telephone Number:
Primary Language Spoken/Mean of Communication:	
Date of Admission (if applicable):	
Level of Supervision (check all applicable)	
<input type="checkbox"/> Requires minimal supervision <input type="checkbox"/> Independent in community <input type="checkbox"/> Uses public transportation safety <input type="checkbox"/> Drives own vehicle	<input type="checkbox"/> Tends to wander <input type="checkbox"/> Unaware of unsafe areas <input type="checkbox"/> Unsafe if leaves home unattended <input type="checkbox"/> Requires 24-hour direct supervision
Mobility Needs (check all applicable)	
<input type="checkbox"/> Unable to move from one location to another without physical assistance from others <input type="checkbox"/> Unable to move from one location to another without oral prompting from others <input type="checkbox"/> Difficulty understanding and following oral directions in the event of an emergency <input type="checkbox"/> Independently mobile with ambulation device. Specify device used _____ <input type="checkbox"/> Walks without assistance	
Sensory Needs (check all applicable)	
<input type="checkbox"/> Total hearing impairment <input type="checkbox"/> Hears with device Device: _____	<input type="checkbox"/> Total visual impairment <input type="checkbox"/> Sees with device Device: _____
Diagnosis: Include medical, cognitive, and behavioral diagnosis	
Medications (check all applicable)	
<input type="checkbox"/> Can self-administer medications with no assistance from others <input type="checkbox"/> Can self-administer medications with assistance to store medications in a secure place <input type="checkbox"/> Can self-administer medications with assistance in remembering schedule <input type="checkbox"/> Can self-administer medications with assistance in offering medications at prescribed times <input type="checkbox"/> Can self-administer medications with assistance in opening container or locked storage area <p align="center">OR (check)</p> <input type="checkbox"/> Cannot self-administer medications	
Activities of Daily Living – Needs help with (check all applicable):	
<input type="checkbox"/> Eating <input type="checkbox"/> Transferring in/out of bed/chair <input type="checkbox"/> Drinking <input type="checkbox"/> Toileting/Bladder <input type="checkbox"/> Ambulating	<input type="checkbox"/> Toileting/bowel <input type="checkbox"/> Managing health care <input type="checkbox"/> Personal hygiene/dressing <input type="checkbox"/> Securing health care <input type="checkbox"/> Turning and positioning in bed/chair
Instrumental Activities of Daily Living – Needs help with (check all applicable):	
<input type="checkbox"/> Personal laundry <input type="checkbox"/> Shopping <input type="checkbox"/> Securing and using transportation <input type="checkbox"/> Managing finances <input type="checkbox"/> Using the telephone <input type="checkbox"/> Making and keeping appointments	<input type="checkbox"/> Caring for personal possessions <input type="checkbox"/> Writing correspondence/reading <input type="checkbox"/> Engaging in social and leisure activities <input type="checkbox"/> Using a prosthetic device <input type="checkbox"/> Obtaining clean, season clothing <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____
Medical Care (check all applicable)	
<input type="checkbox"/> Non-self-care gastrointestinal feedings* <input type="checkbox"/> Naso-gastric feedings* <input type="checkbox"/> Third stage or multiple decubi (bed sores)* <input type="checkbox"/> Intravenous fluids/medications* <input type="checkbox"/> Non-self-care oxygen* <input type="checkbox"/> Catheter Care/oxygen monitoring* <input type="checkbox"/> Incontinence of bladder	<input type="checkbox"/> Incontinence of bowel <input type="checkbox"/> Tracheotomy monitoring <input type="checkbox"/> Blood pressure monitoring <input type="checkbox"/> Non-self-care inhalation therapy <input type="checkbox"/> Colostomy monitoring <input type="checkbox"/> Special skin care precautions <input type="checkbox"/> Other (specify) _____ *Date/Health Care Source of Referral for Medical follow-up _____

Other special care needs _____

Behavioral Needs: _____

Cognitive Screening (a physician or geriatric assessment team must complete this shaded portion)
(to be completed within 72 hours prior to admission to secure dementia care)

Date of completion of cognitive screening: _____

Diagnosis: _____

Behaviors Exhibited:

<input type="checkbox"/> Anxious	<input type="checkbox"/> Disoriented
<input type="checkbox"/> Agitated	<input type="checkbox"/> Hostile
<input type="checkbox"/> Confused	<input type="checkbox"/> Physically violent
<input type="checkbox"/> Delusions	<input type="checkbox"/> Lethargic
<input type="checkbox"/> Wanders	<input type="checkbox"/> Hallucinates
<input type="checkbox"/> Sad/Tearful	

Stage of dementia/observations _____

Name of consulting physician or geriatric assessment team _____ **Date** _____

Signature of consulting physician or geriatric assessment team _____ **Date** _____

The needs of this individual can be met by the services provided by this personal care home Yes No
(circle one)

If no, specify referral location for appropriate services _____

Date preadmission screening completed _____

Who assisted in completing preadmission screening (check all applicable)

Resident

Resident's family member: Name: _____

Address: _____

Telephone: _____

Resident's designated person: Name: _____

Address: _____

Telephone: _____

Other: Name: _____

Title/Relationship to Resident: _____

Address: _____

Telephone: _____

Name of person completing preadmission screening _____ **Date** _____

Title of person completing preadmission screening _____

Signature of person completing preadmission screening _____ **Date** _____