PREADMISSION/ EVALUATION QUESTIONNAIRE

Date:

Applicant (Client) Name:
DOB: **Ht / Wt:**
Current Residence:
Referring Agency:
Legal Status:
Insurance coverage: ☐ Medi-Cal ☐ Private Insurance Carrier _____

Diagnosis

DSM IV diagnosis: **By whom:** **Date:**

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

PREPLACEMENT APPRAISAL INFORMATION

Reason for Referral:

Needs different level of care. SNF services no longer needed to meet his needs.

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

II. Independent Living Skills

AMBULATORY STATUS (this person is ☐ ambulatory ☐ non-ambulatory)
Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
☐	☐	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☐	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☐	Able to use evacuation routes including stairs if necessary.
☐	☐	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
☐	☐	Active, requires no personal help of any kind - able to go up and down stairs easily		
☐	☐	Active, but has difficulty climbing or descending stairs		
☐	☐	Uses brace or crutch		
☐	☐	Feeble or slow		
☐	☐	Uses walker. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Uses wheelchair. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Requires grab bars in bathroom		
☐	☐	Other: (Describe)		

SERVICES NEEDED (Check items and explain)

YES	NO	
☐	☐	Help in transferring in and out of bed and dressing
☐	☐	Help with bathing, hair care, personal hygiene
☐	☐	Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
☐	☐	Help with moving about the facility

☐ ☐ Help with eating (need for adaptive devices or assistance from another person)

☐ ☐ Special diet/observation of food intake

☐ ☐ Toileting, including assistance equipment, or assistance of another person

☐ ☐ Continence, bowel or bladder control. Are assistive devices such as a catheter required?

☐ ☐ Help with medication

☐ ☐ Needs special observation/night supervision (due to confusion, forgetfulness, wandering)

☐ ☐ Help in managing own cash resources

☐ ☐ Help in participating in activity programs

☐ ☐ Special medical attention

☐ ☐ Assistance in incidental health and medical care

☐ ☐ Other "Services Needed" not identified above

Does the applicant use any of the following?

Yes No

☐ ☐ Cane. If yes, explain.

☐ ☐ Crutch. If yes, explain.

☐ ☐ Walker. If yes, explain.

☐ ☐ Wheelchair. If yes, explain.

☐ ☐ Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed)

☐ ☐ Does the applicant require a special diet? If yes, explain.

☐ ☐ Does the applicant have any skin condition or history of skin breakdown? If yes, explain.

☐ ☐ Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often?

III. Communication Abilities

Indicate current level of functioning, areas of concern, perceived or diagnosed, need for additional assessment.

A. **Primary/Secondary Language:**

B. **Receptive Language Abilities:**

C. **Expressive Language Abilities:**

D. **Primary Mode of Communication**
☐ verbal ☐ gestural ☐ sign language ☐ picture exchange

IV. Challenging Behaviors

A. BEHAVIORS (low to high risk)

Does the applicant have a history of any of the following behaviors?

YES	NO		YES	NO	
☐	☐	1. Non-compliance	☐	☐	9. Refusal of medical treatment
☐	☐	2. Temper tantrums	☐	☐	10. Refusal to attend therapy
☐	☐	3. Verbal abusiveness	☐	☐	11. Stealing
☐	☐	4. Physical aggression	☐	☐	12. Wandering
☐	☐	5. Property destruction	☐	☐	13. Careless disposal of smoking materials.
☐	☐	6. Violence toward self			
☐	☐	7. Disruptiveness (screaming, throwing things, argumentative)	☐	☐	14. Refusal to bathe or wear clean clothing
☐	☐	8. Refusal to take medications	☐	☐	15. Non-Compliance with house rules

If the answer to any of the above is yes, please describe.

B. BEHAVIORS (high risk) **(possible exclusionary criteria)**

Does the individual have a history of any of the following?

YES	NO	
☐	☐	**Requires sexual offender treatment** (possible exclusionary criteria)
☐	☐	1. Sexual assaultiveness, molestation or inappropriate sexual activity.
☐	☐	2. Sexual acting out (i.e., public masturbation, flashing, initiate contact with peers)
☐	☐	3. AWOL / bolting / leaving approved areas
☐	☐	4. Ingestion of toxic substances
☐	☐	5. Ingestion of dangerous items/objects
☐	☐	6. Attempts to poison others
☐	☐	7. Self destructive behavior (i.e., self-mutilation)
☐	☐	8. Suicidal attempts or suicidal thoughts
☐	☐	9. Homicidal gestures and/or attempts
☐	☐	10. Depression

C. BEHAVIORS (Delinquency-High Risk) **(possible exclusionary criteria)**

Does the client have a history of any of the following:

YES	NO	
☐	☐	1. Offenses against people
☐	☐	2. Probation
☐	☐	3. History of arrests
☐	☐	4. Offenses against property
☐	☐	5. Drug or alcohol related offenses
☐	☐	6. Use of weapons
☐	☐	7. Arson
☐	☐	8. Sexual offenses
☐	☐	9. Truancy
☐	☐	10. Runaway
☐	☐	11. Gang activity
☐	☐	Is the client a registered sex offender? If yes, please provide information on offense(s)

D. ALCOHOL/ DRUG USE

Does the client have a history of any of the following:
(possible exclusionary criteria)

YES	NO	
☐	☐	**Require Substance Abuse Treatment**
☐	☐	1. Drug use
☐	☐	2. Alcohol use
☐	☐	3. Use of inhalants
☐	☐	4. Use of injectable drugs
☐	☐	5. Treatment for drug abuse
☐	☐	6. Treatment for alcohol abuse
☐	☐	7. Abuse of over the counter medications

If the answer to any of the above is yes, please describe:

Types of drugs, alcohol, or inhalants used:

Frequency of use of above (requires rehabilitation y / n):

Approximate date of last known use of the above:

V. Day Program (Adult Day)

Is there a current Day Program? ☐ **Yes** ☐ **No**

Describe:

VI. Learning Abilities

(Please indicate the nature of any perceived or diagnosed cognitive delays or learning difficulties)

YES NO

☐ ☐ 1. Emotional disturbance
☐ ☐ 2. Mental retardation (specify IQ and level of MR)
(see guidelines below to determine if they meet exclusionary criteria)
☐ ☐ 3. Learning Disability (type)
☐ ☐ 4. Combination (please describe below)
☐ ☐ 5. IQ is above borderline intellectual functioning **(possible exclusionary criteria)**

VII. Medical/Health

A. HEALTH STATUS

Client's primary physician's name: Physician's phone:

YES NO

☐ ☐ Does the applicant currently use any prescription or over-the-counter medications? If yes, please list.

Medication Name	Reason for Rx	Strength	Dose	Times

YES NO

☐ ☐ 1. Does the applicant currently use any prescription or over-the-counter medications on a PRN basis? If yes, please list.
(PRN letter signed by the applicant's physician required. See 87465) (b)(c)(d)(e)

☐ ☐ 2. Does the applicant have any emergency medication that must be kept with him/her or at bedside? If yes, please list.

☐ ☐ 3. Will the applicant be willing to have all of his/her medications, including over-the-counter medications, centrally stored?

4. Does the applicant use any of the following devices?

Yes	No	
☐	☐	Glasses
☐	☐	Dentures
☐	☐	Hearing Aid
☐	☐	Other

Does the client have any of the following?

Yes	No	
☐	☐	1. Asthma
☐	☐	2. Epilepsy (instability in seizure activity y / n) (**possible exclusionary criteria**)
☐	☐	3. Allergies
☐	☐	4. Diabetes
☐	☐	5. Eating Disorder
☐	☐	6. Visual Impairment
☐	☐	7. Hearing Impairment
☐	☐	8. Infectious Disease **(possible exclusionary criteria)**
☐	☐	9. Special Diet
☐	☐	10. Pregnancy **(possible exclusionary criteria)**
☐	☐	11. Chronic medical conditions
☐	☐	12. Physical limitations (limited ambulatory status y / n)
☐	☐	13. Immunizations not current
☐	☐	14. Dental condition
☐	☐	15. Other conditions not noted above

TUBERCULOSIS INFORMATION

DATE OF TB TEST

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

☐ **YES** ☐ **NO**

☐ POSITIVE

☐ NEGATIVE

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

ACTION TAKEN (IF POSITIVE)

☐ **YES** ☐ **NO**

GIVE DETAILS:

B. PERSONS WITH DEMENTIA

YES NO

☐ ☐ Does the applicant have Dementia?

☐ ☐ Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. (See 87705)

☐ ☐ Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. (See 87705)

SIGNATURES:

Placement Worker: _____ **Date:** _____

Devereux Representative: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

Applicant (individual) _____ **Date:** _____

----------(SECTION TO BE COMPLETED BY DEVEREUX TEAM)----------

DEVEREUX TEAM PARTICIPANTS:

PROGRAM(S): ☐ Mark Villa ☐ Weisman Center ☐ CSDP ☐ DTAC ☐ LEP ☐ SLS/ILS

DECISION:

(☐ appropriate ☐ not appropriate ☐ provisional acceptance ☐ 1:1 residential ☐ 1:1 day

Pre-Admit Questionnaire - Weisman
Attachment A (optional)

A. INCIDENTAL MEDICAL SERVICES ASSESSMENT

1. Oxygen Administration

Yes No

☐ ☐ Does the applicant use oxygen? If yes, explain. (See 87618)

☐ ☐ Does the applicant need assistance? If yes, explain. (Exception required. See 87618)

☐ ☐ Does the applicant use liquid oxygen? If yes, explain. (Exception required. See 87618(c)(1)

2. Intermittent Positive Pressure Breathing (IPPB) Machine

Yes No

☐ ☐ Does the applicant use an IPPB? If yes, explain. (See 87619)

☐ ☐ Does the applicant need assistance? If yes, explain. (Exception required. See 87619)

3. Colostomy/Ileostomy

Yes No

☐ ☐ Does the applicant have a colostomy or ileostomy? If yes, explain. (See 87621)

☐ ☐ Does the applicant need assistance? If yes, explain (Exception required. See 87621)

4. Enema/Suppository/Fecal Impaction Removal

Yes No

☐ ☐ Does the applicant need enemas, suppositories or fecal impaction removal? (See 87622)

If yes, explain

☐ ☐ Does the applicant need assistance? If yes, explain. (See 87622)

(Procedures must be performed by an Appropriately Skilled Professional [ASP])

5. Catheter Care

Yes No

☐ ☐ Does the applicant have a catheter? If yes, explain. (See 87623)

☐ ☐ Does the applicant need assistance? If yes, explain.
(Some procedures must be performed by an ASP)

6. Bowel and Bladder Incontinence

Yes No

☐ ☐ Is the applicant incontinent of bowel or bladder? If yes, explain.
(See 87625)

7. Contractures

Yes No

☐ ☐ Does the applicant have contractures? If yes, explain.
(See 87626)

☐ ☐ Does the applicant need assistance? If yes, explain.
(Exception required. See 87626)

☐ ☐ Do the contractures severely affect the applicant's ability to function?
(If yes, not allowed in an RCFE. See 87626)

8. Diabetes

Yes No

☐ ☐ Does the applicant have diabetes? If yes, explain.
(See 87628)

☐ ☐ Does the applicant require assistance with performing or reading glucose tests, drawing up injectable medications or administering injections? If yes, explain.
(See 87628) (Procedures must be performed by an ASP)

9. Injections

Yes No

☐ ☐ Does the applicant need any injections? If yes, explain. (See 87629)

☐ ☐ Does the applicant need assistance with drawing up and administering the injections? If yes, explain.
(See 87629) (Procedures must be performed by an ASP)