AMDC PARTICIPANT QUALITY OF CARE REVIEW

Center:_____

Surveyor:_____ **Date:**_____

PLEASE NOTE: This form requires documentation/records that minimally will be reviewed during the survey process. The surveyor may request additional documentation/records as needed to complete the survey process in accordance with 10.12.04.07 B. Records and Reports.(1) A licensee shall maintain records and make reports as required by the Department.(2) The records and reports shall be open to inspection by the Department or any agency designated by the Department.(3) On request, a licensee shall immediately provide copies of records and reports, policies and procedures, including medical records of current participants, participants discharged within the last 6 months, personnel records of current staff, and those records and reports relating to quality assurance activities to the Department or any agency designated by the Department.(4) All other records and reports may be stored off-site, but shall be available to the Department within 24 hours of request.

NAME:_____ # OF DAYS ATTENDS CENTER:_____
LAST FIRST M.I.

MA/Medicare/Private Insurance #: ____Y____N

SEX:_____ DOB:_____ D.O.A._____

ADDRESS:_____
STREET CITY STATE ZIP CODE

LIVING ARRANGEMENTS: BY SELF:____ WITH FAMILY:_____ ASSISTED LIVING PROVIDER (Please include name of AL Provider):_____ OTHER RESIDENTIAL SETTING (Please include name/type of other residential provider):_____

DIRECTIONS TO HOME IN CHART: Y_____ N_____ RESPONSIBLE PARTY:_____

PRIMARY CARE PROVIDER: NAME:_____

ADDRESS:_____

PRIMARY DIAGNOSIS:_____

SECONDARY DIAGNOSIS:_____

ADAPTIVE EQUIPMENT:_____

ALLERGIES:_____

DIET: _____

MEDICATION: MAY SELF MEDICATE: _____ MAY NOT SELF MEDICATE: _____ PILLBOX: Y____ N____

PHYSICAL EXAM COMPLETED WITHIN 45 DAYS OF ADMISSION: Y_____ N_____
SIGNED AND DATED BY MD: Y____ N_____

IS PARTICIPANT FREE OF INFECTIOUS TUBERCULOSIS: Y____ N____
DETERMINED/DATE: CHEST X-RAY_____
SKIN TEST_____
RESULTS_____

AMDC PARTICIPANT QUALITY OF CARE REVIEW

Center:_____

Surveyor:_____ **Date:**_____

INITIAL MD ORDER DATE:_____

LABWORK:_____

REMARKS:_____

_____

_____

_____

_____

_____

_____

ADCAPS:

DATES: _____ _____ _____ _____ _____

WEIGHTS: _____ _____ _____ _____ _____

BP: _____ _____ _____ _____ _____

PULSE: _____ _____ _____ _____ _____

REMARKS: _____

PCP – PROBLEMS:

CARE PLAN	REVIEW DATE

AMDC PARTICIPANT QUALITY OF CARE REVIEW

Center:_____

Surveyor:_____ **Date:**_____

REMARKS:_____

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS/DOSE/SCHEDULE DIAGNOSIS EXIST FOR USE OF MEDS

MEDICATION, TREATMENT AND DIET ORDERS UPDATED WITHIN AS SPECIFIED:_____

_____

VERBAL ORDERS ARE WRITTEN IMMEDIATELY IN THE PARTICIPANT'S RECORD, SIGNED AND DATED:_____

_____

ORIGINALS OF VERBAL/FAXED ORDERS PLACED IN THE MEDICAL RECORD WITHIN 10 CALENDAR DAYS AFTER THE DATE OF THE TELEPHONE ORDER:_____

MEDICATION ADMINISTERED DURING CENTER HOURS:_____

_____

AMDC PARTICIPANT QUALITY OF CARE REVIEW

Center:_____

Surveyor:_____ **Date:**_____

MEDICATION CHANGES IN LAST 90 DAYS:_____

_____

_____

_____

MEDICATIONS REACTIONS: _____

_____

_____

M.D. NOTIFIED: _____

_____

ADDITIONAL NOTES/COMMENTS

Center:_____

Surveyor:_____ **Date:**_____

Center:_____

Surveyor:_____ **Date:**_____
