

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: _____
LAST FIRST M.I.

OF DAYS ATTENDS CENTER: _____

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

MA/Medicare/Private Insurance #: ____Y____N

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 _____

