

# Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

## INSTRUCTIONS FOR USE

### Personal Care Home

#### Applicable Regulations

##### § 2600.141

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

#### Homes are **PERMITTED** to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature and certification of accuracy at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

#### Homes are **PROHIBITED** from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

**It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.**



# Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

**Licensed Setting:  
Personal Care Home**

Resident Information	Evaluation Information		
Name:	Type (Check one)	Date of In Person Evaluation:	Date Form Completed:
Date of Birth:	<input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL <input type="checkbox"/> STATUS CHANGE		

**(1) - General Physical Examination**

Height:	Weight:	Pulse Rate:	Blood Pressure:	Temperature:
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(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable
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1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

For additional diagnoses, see **Diagnoses Addendum** on page 4.

(4) Poisonous Materials	(5) - Advanced Directives
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<input type="checkbox"/> This resident CAN safely use or avoid poisonous materials <input type="checkbox"/> This resident CAN NOT safely use or avoid poisonous materials	<input type="checkbox"/> Yes <input type="checkbox"/> No  Check One: <input type="checkbox"/> Full Code <input type="checkbox"/> DNR (Do Not Resuscitate)
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(6) - Special Health or Dietary Needs	(7) - Allergies
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<input type="checkbox"/> None <input type="checkbox"/> Special Diet - Check all that apply <input type="checkbox"/> No Added Sodium <input type="checkbox"/> Low Cholesterol <input type="checkbox"/> Heart Healthy <input type="checkbox"/> Mechanical Soft Foods <input type="checkbox"/> Pureed Foods <input type="checkbox"/> No Concentrated Sweets <input type="checkbox"/> Respiratory Care Describe: _____ <input type="checkbox"/> Wound Care <input type="checkbox"/> Other - See <b>Needs Addendum</b> on page 4	<input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Listed Below:
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<b>(8) - Medications</b>		<b>(9) - Immunization History</b>			
<input type="checkbox"/> None <b>OR</b> See <b>Medication Addendum</b> on page 4		Are immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>Ability to Self-Administer Medications - Check all that apply:</b> <input type="checkbox"/> Can self-administer - no assistance from others. <input type="checkbox"/> Can self-administer -assistance to store medication in a secure place <input type="checkbox"/> Can self-administer - assistance in remembering schedule. <input type="checkbox"/> Can self-administer - assistance in offering medication at prescribed times. <input type="checkbox"/> Can self-administer some medications but not others - See <b>Medication Addendum</b> on page 4 <b>OR</b> <input type="checkbox"/> Cannot self-administer medications.		Td/Tdap Date: _____ Type: _____		Influenza Date: _____	
		Pneumonia Date: _____		Covid Date: _____	
		TB Test Date:_____ Type: <input type="checkbox"/> Skin <input type="checkbox"/> Blood Chest X-Ray Date:_____			
		Other Immunization - (List Date and Type): _____			
<b>(10) - Body Positioning / Movement - Level of Assistance for Ambulation or Transfers</b>		<b>(11) - Health Status</b>		<b>(12) - Cognitive Functioning (Check All That Apply)</b>	
<input type="checkbox"/> None <input type="checkbox"/> Assistive devices and/or wheelchair: Listed: _____ <input type="checkbox"/> Supervision <input type="checkbox"/> Cueing <input type="checkbox"/> One person assist <input type="checkbox"/> Two person assist <input type="checkbox"/> Assist with repositioning <input type="checkbox"/> Assist with turning <input type="checkbox"/> Assist with transfers		<input type="checkbox"/> Excellent <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Actively Dying <input type="checkbox"/> Fair		<input type="checkbox"/> No impairment/Independent <input type="checkbox"/> Short term memory deficits <input type="checkbox"/> Long term memory deficits <input type="checkbox"/> Needs assist with high level decision making <input type="checkbox"/> Needs assist with all decision making <input type="checkbox"/> Dementia diagnosis <input type="checkbox"/> Brain injury	
<b>(13) Mobility Needs Assessment (For Ability To Evacuate In An Emergency)</b>	<input type="checkbox"/> <b>Independent (Mobile)</b> Resident has <b>no</b> mobility needs and can evacuate independently in an emergency	<input type="checkbox"/> <b>Minimal (Mobile)</b> Resident requires <b>limited</b> physical or oral assistance to evacuate in an emergency	<input type="checkbox"/> <b>Moderate (Immobile)</b> Resident requires <b>moderate</b> physical or oral assistance to evacuate in an emergency	<input type="checkbox"/> <b>Total (Immobile)</b> Resident requires <b>total</b> physical or oral assistance to evacuate in an emergency from one or more staff persons	
	<b>(14) Special Care Needs (For Secure Dementia Care Unit Admissions Only)</b>				
	<b>Dementia</b>				
	Does resident require dementia - related care in a secured area? <input type="checkbox"/> YES <input type="checkbox"/> NO				



**Documentation of Medical Evaluation (DME) - Addendum Sheet**  
 This sheet may be copied as needed if additional space is required

Resident Information		Evaluation Information	
Name:		Date of In Person Evaluation:	Date Form Completed:

**Diagnoses Addendum**

(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

**(6) Needs Addendum**

Other (describe):

**(8) Medication Addendum**

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.

## Medical Professional Information

### By Signing Below, I certify that:

- I am a physician, physician assistant, or certified registered nurse practitioner whose license to practice is in good standing.
- The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
- The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600.

### Check One Of The Options Below:

- The resident's needs can be met safely at the Personal Care Home.
- The resident is Nursing Facility Clinically Eligible (NFCE). Services to be provided at home or in a nursing facility. The resident's needs CAN NOT be met safely at the Personal Care Home.

**Medical Professional Name:**

**Medical Professional License #:**

**Medical Professional Signature:**

**Date Signed:**

