Dubie's Love
Residential Services, LLC.

ID DIAGNOSIS SCREENING QUICK FORM

Initial Contact Date:	Method of Screening: ☐ Telephone ☐ Face to Face ☐ _____
Screening Employee's Name:	

1. IDENTIFICATION/BACKGROUND *All questions on this form must be answered – write NA if not applicable*

Vital and Demographic Information

Last Name	First Name	MI	Date of Birth:	Social Security No.:
Address	City	State	Zip Code	
County	Home Phone ( )	Work Phone ( )	Other Phone (pager, cell, etc) ( )	
Directions to House:				
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

Primary Caregiver/Emergency Contact/Primary Physician

Name:	Relationship:
Address:	Phone Numbers: (H) (W)
Name:	Relationship:
Address:	Phone Numbers: (H) (W)
Name of Primary Physician:	Phone Numbers: (H) (W)
Address:	

Initial Contact

Name of Person Who Called:	Relationship to Applicant:	Phone Numbers: (H) (W)

2. PHYSICAL HEALTH ASSESSMENT

Presenting Need/Problem/Diagnosis

A copy of this signed form is as valid as the original.

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Please check which areas there is a need for service:
☐ Residential ☐ Day Support ☐ Physical Health ☐ Money Management ☐ Transportation ☐ Medication
☐ Vocational Training ☐ No Primary Caregiver ☐ Other (please specify) _____

Psychiatric Needs (include current and pass counseling or psychiatric services and hospitalizations (List precipitating factors). Attach any psychological, psychiatric and neurological exams and reports available):

Applicant's Name:	Social Security Number:

2. PHYSICAL HEALTH ASSESSMENT (Continued)

Current Medical Problems (List past serious illnesses, infectious diseases, serious injuries and non-psychiatric hospitalizations):

Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

Physician Review:
Is a physical examination completed and signed by a licensed physician in the last 12 months attached?
☐ Yes
☐ No, physical examination must be taken by a licensed physician
Comments: _____

History of Medical Care (in the past 12 months have you been admitted for medical or rehabilitation reasons):

Yes	No		Name of Place	Date Admitted	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have spells such as seizures, convulsions with high temperatures, fainting spells or staring spells? If so, describe and make a note of special instructions to be followed in the event that this happens.

Do you have any known problems that make it hard to eat?

Yes	No		Yes	No	

		Food Allergies			Problem Swallowing
		Inadequate Food/Fluid Intake			Taste Problems
		Nausea/Vomiting/Diarrhea			Tooth or Mouth Problems
		Problem Eating Certain Foods			Other (Explain):
		Problem Following Special Diets			

Nutrition

Do you have any special diet requirements? If so, please explain:

☐ None ☐ Low Fat/Cholesterol ☐ No/Low Salt ☐ No/Low Sugar ☐ Combination/Other

Comments: _____

_____

_

Do you take dietary supplements?

☐ None ☐ Occasionally ☐ Daily, Not Primary Source ☐ Daily, Primary Source ☐ Daily, Sole Source

Comments: _____

_____

Do you have a substance abuse history? ☐ Yes ☐ No If yes, please explain:

Current Medications

Drugs Name (Prescriptions and Over-the-Counter	Dose	Frequency	Route	Reason(s) Prescribed

Yes	No		Check One	
		Adverse reactions/allergies		Without assistance
		Cost of medication		Administered/monitored by lay person
		Getting to the pharmacy		Administered/monitored by direct care staff
		Taking them as instructed/prescribed	Describe Help:	

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Will admission pose significant risk to the applicant, residents or facility staff? ☐ Yes ☐ No		
Has sufficient information been gathered to develop a service plan? ☐ Yes ☐ No		
Admit applicant into program? ☐ Yes ☐ No ☐ Placing on waiting list.		Date:
Signature of Program Director:	Date:	Screening Completion Date:
Signature of QMRP/QMHP:		Date: