Adult Residential Licensing - Documentation of Medical Evaluation (DME)
INSTRUCTIONS FOR USE

Applicable Regulations

§ 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

§ 2600.141(a)(2) - The medical evaluation shall include the following:
(1) A general physical examination by a physician, physician's assistant or nurse practitioner.
(2) Medical diagnosis including physical or mental disabilities of the resident, if any.
(3) Medical information pertinent to diagnosis and treatment in case of an emergency.
(4) Special health or dietary needs of the resident.
(5) Allergies.
(6) Immunization history.
(7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
(8) Body positioning and movement stimulation for residents, if appropriate.
(9) Health status.
(10) Mobility assessment, updated annually or at the Department's request.

§ 2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

§ 2600.141(b)(2) - A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.

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 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.

Adult Residential Licensing - Documentation of Medical Evaluation (DME)

Resident Information	**Evaluation Information**		
Name:	Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date Resident Evaluated:	Date Form Completed:
Date of Birth:			

(1) - General Physical Examination	Height:	Weight:	Pulse Rate:
Blood Pressure:	Temperature:		

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	

FOR ADDITIONAL DIAGNOSES, SEE "DIAGNOSES ADDENDUM" BELOW

(4) Special Health or Dietary Needs

☐ None
☐ This resident **CAN** safely use or avoid poisonous materials
☐ Secured Dementia Care (For SDCU admissions only)
☐ Other - SEE "NEEDS ADDENDUM" BELOW

(6) - Immunization History

Are immunizations current? ☐ Yes ☐ No ☐ Unknown

Td/Tdap Date:	Influenza Date:

Other Immunizations (List Date and Type):

(5) - Allergies

☐ None ☐ Unknown ☐ Listed Below:

(7) - Medications

☐ None

OR SEE "MEDICATION ADDENDUM" BELOW

Ability to Self-Administer Medications - Check all that apply:

☐ Can self-administer - no assistance from others
☐ Can self-administer - assistance to store medications in a secure place
☐ Can self-administer - assistance in remembering schedule
☐ Can self-administer - assistance in offering medications at prescribed times
☐ Can self-administer - assistance in opening container or locked storage area
☐ Can self-administer some medications but not others - See MED. ADDENDUM
OR
☐ Cannot self-administer medications

(8) Body Positioning / Movement

☐ None ☐ Listed Below:

(9) - Health Status		**Cognitive Functioning**	
☐ Excellent	☐ Poor	☐ Excellent	☐ Poor
☐ Good	☐ Actively Dying	☐ Good	☐ None
☐ Fair		☐ Fair	

(10) Mobility Needs Assessment				
☐ Independent (Mobile) Resident has **no** mobility needs and can evacuate independently in an emergency	☐ Minimal (Mobile) Resident requires **limited** physical or oral assistance to evacuate in an emergency	☐ Moderate (Immobile) Resident requires **moderate** physical or oral assistance to evacuate in an emergency	☐ Total (Immobile) Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons	

Medical Professional Information

By signing below, I certify that:

- I am a physician, physician's 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

Medical Professional Name:	**Medical Professional License #:**
Medical Professional Signature:	**Date Signed:**

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 Resident Examined:	Date Form Completed:

Diagnoses Addendum

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

(4) Needs Addendum

☐ Special Diet - Check all that apply

☐ No Added Sodium
☐ Low cholesterol
☐ Mechanical Soft Foods
☐ Heart Healthy
☐ Pureed Foods
☐ No Concentrated Sweets

Other (describe):

☐ Special Health Needs - Include Description

(7) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐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.**