

**NEW YORK STATE HEALTH DEPARTMENT NUMERICAL STANDARDS MASTER SHEET
 NUMERICAL STANDARDS FOR APPLICATION FOR THE LONG TERM CARE PLACEMENT FORM
 MEDICAL ASSESSMENT ABSTRACT
 (DMS-1)**

3.a.

Nursing Care and Therapy (Specify details in 3d, 3e or attachment)	Frequency			Self Care		Can Be Trained	
	None	Day Shift	Night/Eve. Shift	Yes	No	Yes	No
Parenteral Meds	0	25	60	-15	0	0	0
Inhalation Treatment	0	38	37	-20	0	0	0
Oxygen	0	49	49	-4	0	0	0
Suctioning	0	50	50	-1	0	0	0
Aseptic Dressing	0	42	48	0	0	+1	0
Lesion Irrigation	0	49	49	-20	0	0	0
Cath/Tube Irrigation	0	35	60	-1	0	+4	0
Ostomy Care							
Parenteral Fluids	0	50	50				
Tube Feedings	0	50	50				
Bowel/Bladder Rehab.	0	48	48				
Bedsore Treatment	0	50	50				
Other (Describe)	0	0	0				

b.

Incontinent

Urine: Often* [] 20 Seldom** [] 10 Never [] 0 Foley [] 15
 Stool: Often* [] 40 Seldom** [] 20 Never [] 0

c.

Does patient need a special diet? No [] Yes []

If yes, describe _____

4.

Function Status	Self Care	Some Help	Total Help	Cannot
Walks with or w/o aids	0	35	70	105
Transferring	0	6	12	18
Wheeling	0	1	2	3
Eating/Feeding	0	25	50	
Toileting	0	7	14	
Bathing	0	17	24	
Dressing	0	40	80	

5.

Mental Status	Never	Sometimes	Always
Alert	40	20	0
Impaired Judgement	0	15	30
Agitated (nighttime)	0	10	20
Hallucinates	0	1	2
Severe Depression			*
Assaultive	0	40	80
Abusive	0	25	50
Restraint Order	0	40	80
Regressive Behavior	0	30	60
Wanders			
Other (Specify)			

6.

Impairments	None	Partial	Total
Sight	0	1	2
Hearing	0	1	2
Speech	0	10	20
Communications			
Other (Contractures, etc.)			

7.

Short Term Rehab. Therapy Plan (To be completed by Therapist)

a. Describe Condition (not Dx) Short Term Plan of Treatment & Achievement Date
 Needing Intervention Eval. and Progress in last 2 weeks

b. Circle Minimum number of days/week of skilled therapy from each of the following:

REQUIRES

RECEIVES

0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

+ 37 for skilled rehab/therapy (received & required both>0)