

SUBJECT: PHYSICAL HEALTH ASSESSMENT

APPROVED BY:

EFFECTIVE

DATE: 08-17-09 (replaces 01-17-06)

Medical Director

Reviewed (no changes:) 02-04-11 \_\_\_\_\_  
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Executive Director

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POLICY

It is the policy of McIntosh Trail CSB that the assessment of medical/physical status will be a part of the comprehensive assessment process for all consumers.

PROCEDURE

1. Physical health screening includes, but is not limited to: significant known diagnoses; significant known past treatment procedures; past and current diagnoses or problems; known adverse and allergic drug actions; currently and recently used medications; and individuals with pain or at risk for pain.
  - A. Initial screening occurs at the time of intake/admission when the assessment forms completed by the consumer are reviewed with the intake clinician.
  - B. The data to be collected within the biopsychosocial assessment includes current physical problems, pain problems, nutritional status and dietary habits, substance use and abuse, medication history, hospitalizations, allergies, treating physicians, any past but inactive medical problems, and pregnancy status.
  - C. Time frame for review of the data collected at intake is a function of service disability and need. (See Policy 2110).
  - D. Medical staff will recommend further physical health assessment, within the resources available, when there are:
    1. Active medical problems such as hypertension, diabetes, seizures, positive PPD, or cardiopulmonary disorders which are known and untreated.
    2. Pain management problems not responding to current treatments.
    3. Signs and symptoms of active medical problems which are not responding to current treatment, including tardive dyskinesia.
    4. Symptoms that would be better accounted for by physical illness.
    5. Pre-treatment physical examination is required or recommended as a prerequisite to psychiatric medications.
    6. Other physical health conditions present a barrier to behavioral health care.
    7. Children and adolescents are prescribed medications on maintenance basis.

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PROCEDURE (Continued)

1. E. Referral for physical examination is not required:
  1. If the illness is stable, with or without current treatment; for example, hypertension or seizures.
  2. If the consumer has a primary care practitioner or pediatrician who is following him or her regularly.
- F. The psychiatric assessment form includes prompts and space to document any recommendation for medical examination and treatment.
- G. Physical assessment of consumers receiving outpatient addictive disease services will meet licensure regulations.
  1. Standing orders include nursing assessment, RPR and PPD for all addictive diseases consumers who have completed the admission forms.
  2. For consumers entering outpatient addictive disease services, a physical health assessment is performed by a nurse as part of the comprehensive assessment process. Referral for further physical health assessment and treatment may occur if indicated.
  3. State-required laboratory studies are part of the initial addictive disease evaluation and will be completed and results documented before the consumer proceeds with addictive disease services.  
Local sites should, at a minimum, have consumer complete and sign the admission forms prior to doing these laboratory studies on site. Consumers may choose to have these studies completed elsewhere, but will provide documentation of results.
2. Physical health assessments in services other than outpatient settings meet the following guidelines:
  - A. Physical health assessment, including medical history and physical exam, is completed annually (not to exceed 30 days after due date) for all consumers in residential treatment services and as indicated for consumers in outpatient services.
  - B. Physical health assessment is part of the initial physician evaluation occurring within 24 hours of admission to the crisis stabilization unit at Pine Woods.
  - C. A comprehensive medical history and physical examination is performed within 24 hours of admission to Pine Woods crisis stabilization and therapeutic foster care.
  - D. A comprehensive medical history and physical examination is performed within one week of admission to all non-intensive residential services.

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PROCEDURE (Continued)

- E. All physical examinations will be performed by a licensed physician or by Clinical Nurse Specialist according to Advance Practice Nurse Protocol.
- F. A comprehensive medical history and physical examination performed within 30 days prior to admission may be used as the physical assessment when:
  - 1. Reviewed and updated as needed by physician or CNS.
  - 2. Documentation of the review is noted in consumer record, particularly on the physical exam form.
  - 3. A legible copy is placed in the consumer record.
- 3. For consumers with MR/DD, the annual requirement for a physical health assessment may be met by qualified private practitioners. A legible copy of the physical assessment/physical exam will be placed in consumer clinical record.
  - A. Whenever possible, McIntosh Trail CSB forms will be utilized.
  - B. The yearly DMA-6 may not replace the annual physical health assessment.
  - C. TB screening will be a part of the annual physical health assessment for consumers in DD Housing Services.