**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 | |
| Tolieting | 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 (nightime) | 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) Needing Intervention | Short Term Plan of Treatment & Eval. and Progress in last 2 weeks | Achievement Date |

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)