MSDP –Physical Health Assessment

- ✓ Required for JCAHO certified programs and some DPH services; completed in concert with the comprehensive assessments.
- ✓ Optional for other programs following agency policies.
- ✓ Assess current and past medical issues of the person served that may impact current functioning.
- ✓ To be completed by qualified Medical Professional.

Data Field	Identifying Information Instruction
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Organization Name	Record the organization for whom you are delivering the service.
Date of Admission	Record the date of admission per agency policy.
Data Field	**Person Served Health Care Providers**
Provider	Complete section for each applicable provider listed
Name and Credentials	List name and credential(s) of each provider of health care for the person
Address	List address of each provider of health care for the person
Tel Number	List telephone number of each provider of health care for the person
Fax	List fax number of each provider of health care for the person
Date of last exam	List the date of the most recent examination for the person.
Data Field	**Allergies**
	List all known food, medication and environmental allergies for the person. Note drug sensitivities. Check *No known allergies* if no allergies/drug sensitivities are known and skip to next section.
Data Field	**Vital Signs**
	Record height, weight, blood pressure, body mass index, respiratory rate, pulse and temperature for person.
Data Field	**Recent Assessments /Examinations**
Most Recent Blood work	Complete section for all applicable assessments and /or examinations. Additional blood work is required for Opiate Treatment Programs (OTP)
Date	Record date of test performed
Results	Record results of test performed
Physician	List name of physician providing test results
Most Recent Screening	Complete section for all applicable screenings. Additional screenings are required for Opiate Treatment Programs (OTP)
Date	Record date of test performed
Results	Record results of test performed
Physician	List name of physician providing test results
Data Field	**Medical Hospitalizations**
Medical Hospitalizations	If the person was not hospitalized recently for medical reasons, check None Reported
Hospital	If the person was hospitalized recently, indicate the hospital name and location for each hospital stay

Date(s) of Service	Record the date(s) of each hospitalization
Reason (Medical Procedure, acute Illness, Birth of Child, Etc)	Record the reason for each hospitalization.
Data Field	**Unresolved Surgical Care Needs**
Unresolved Surgical Care Needs	Explain care needs relative to recently performed surgical procedures
Breastfeeding	Record if the woman is currently breastfeeding a baby
Data Field	**Cardiovascular Illness**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Respiratory System**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Endocrine System**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Neurologic Disorder**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Movement Disorder**
Movement Disorder	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Immune System Disorders**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. If AIDS/HIV status is recorded DPH/DMH regulation requires that the form is kept separate from the regular medical record and secured unless a written authorization was obtained from the person served.
Data Field	**Bacterial/Viral Infections**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Visual Impairment**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Auditory Impairment**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Digestive/Urinary Conditions**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Dental Conditions**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Reproductive Health**

	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Advanced Directives in place**
	Check all boxes that apply.
Data Field	**Pain Assessment Screening**
	Indicate the person's reported level of pain today using zero to 5 point scale
Does pain currently interfere with your daily activities?	Check Yes or No. If yes, indicate the degree to which pain interferes with person's activities.
Data Field	**Ambulation**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Dietary**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Diseases of the Liver**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Dermatologic Conditions**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Cancer**
Have you ever been diagnosed with cancer?	Check Yes or No. If yes, indicate type of cancer and treatments received.
Are you currently in remission?	Check Yes or No. If yes, indicate how long the person has been in remission (years/months).
Data Field	**Bone and Joint Conditions**
	Check all boxes that apply and complete requested details. If none reported, check no and skip to next section.
Have these conditions led to:	Check all boxes that apply.
Data Field	**For Opiate Treatment Programs:**
	For Opiate Treatment Programs a specific comprehensive physical examination, completed by a medical professional, must be attached.
Data Field	**Current Medical Diagnoses**
	Complete table to document all current medical diagnoses for the person served
Data Field	**Comments, Recommendations or Referrals by Medical Reviewer:**
	If no referral needed, skip to signature and credential section.
Data Field	**Check Referral(s) Needed and Specify Action(s)**
	Check all resources needed for referral. Specify reason for referral to provider.
Data Field	**Recommendation shared with person served**
	Check yes or no. If yes, record person's served response to recommendations. If no, indicate how recommendations will be shared with person served.

Data Field	Medical Reviewer Signature/Credentials (PA, NP, MD, DO, Ph.D)
	Provide legible signature, credentials, and the date reviewed for the medical reviewer of this questionnaire.