

Day Activity and Health Services
Utilization Review Report

Client Name	Client No.	Caseworker
DAHS Facility Name		Contract No.

1. Review the nurse's monthly progress notes for the **previous three months**. Check the appropriate boxes:

- Documentation of hospital stay? N/A Yes No
- Documentation of significant changes? N/A Yes No
- Progress notes adequate? Yes No
- Progress note(s) missing? Yes No
- Signature of facility nurse missing? Yes No
- Date of progress note missing? Yes No
- Quality of progress note(s) needs improvement? Yes No

If yes, explain:

Progress notes adequate; no deficiencies noted.

2. Does documentation for previous three months indicate that ordered treatments/procedures were carried out?

- N/A Yes No

If no, specify the problems:

3. Does the facility nurse administer medications to the client?..... Yes No

If yes: A. Is there a physician's order for medications to be administered by the facility nurse?..... Yes No

B. Does the record indicate that medications were given as ordered the previous three months? Yes No

If no, specify the problems:

4. Does client self-administer medications at the facility? Yes No

If yes, is there a statement signed by the attending physician allowing client to self-administer medications while at the facility? Yes No

5. What type of diet is ordered for client?

- General Diabetic Low salt Calorie restricted Other (specify): _____

A. Is the **special diet** being adhered to in meals provided to the client at the facility? N/A Yes No

B. Is the **special diet** being adhered to in snacks provided to the client at the facility?..... N/A Yes No

6. Notes for client interview and/or observation:

7. Describe the client's health problems as stated by the client or observed by the reviewer:

8. Does the client appear to have a continued medical need for DAHS?..... Yes No

If no, explain:

9. Is the client satisfied with the DAHS services?..... Yes No Client unable to respond

If no, specify problems:

10. By observation, does the DAHS facility appear to be meeting the client's needs by providing appropriate:

Assistance when needed (i.e., with toileting, ambulation, eating, personal care, etc.)?..... Yes No

Activities? Yes No

General supervision? Yes No

Nursing supervision?..... Yes No

If any of the above are marked no, explain:

DAHS Client Review Summary

Client Name	Client No.
DAHS Facility Name	Contract No.

SUMMARY OF REVIEW:

- No problems identified during the review of this client.
- Client demonstrates a continued medical need for DAHS services.

The review of this client indicates a need for:

1. Monthly progress notes or improvement in monthly progress notes by facility nurse.
2. Accurate documentation of treatments procedures.
3. Accurate documentation of medication administered at facility.
4. Physician orders for administration or self-administration of medication.
5. Special diet requirements for snacks and/or meals.
6. Denial based on no medical need for DAHS.

Improvement in quality of:

7. assistance provided to client
8. activities
9. general supervision
10. nursing supervision
11. other (specify): _____

Comments/Explanation:

This client and the client's
record were reviewed on

_____ by _____
Date Signature-Regional Nurse Region No.