

RESIDENT HEALTH SCREENING

Minnesota Rules, part 2960.0070, subpart 5(A)(1)

PAGE 1 OF 3

REQUIRED SCREENING CONTENT

The health screening must note the resident's history of abuse and vulnerability to abuse, potential for self-injury, current medications, and most recent physician's and clinic's name, address, and telephone number.

Timing requirement - Minnesota Rules, part 2960.0070, subpart 5(C)(1): The license holder must screen or arrange to have a resident screened according to the timelines in subitems (1) to (3). The health screening in item A, subitem (1), must occur within 24 hours of admission.

1 RESIDENT AND SCREENING INFORMATION

RESIDENT FULL NAME

DATE OF BIRTH

RESIDENT ID

FACILITY / PROGRAM

ADMISSION DATE

ADMISSION TIME

SCREENING DATE

SCREENING TIME

2 HISTORY OF ABUSE AND VULNERABILITY TO ABUSE

Known or reported history of abuse

☒ Yes

☒ No

☒ Unknown

☐ Physical

☐ Sexual

☐ Emotional / psychological

☐ Neglect

☐ Substance abuse

☐ Other

HISTORY DETAILS (include source of information, timing, and relevant circumstances; avoid unnecessary graphic detail)

Current vulnerability to abuse

☒ Yes

☒ No

☒ Unknown

☐ Age / size / development

☐ Disability / communication

☐ Prior victimization

☐ Gender identity / sexual orientation

☐ Peer threats / coercion

☐ Other

VULNERABILITY DETAILS, PROTECTIVE FACTORS, AND ACCOMMODATIONS / SAFETY MEASURES NEEDED

RESIDENT HEALTH SCREENING

Minnesota Rules, part 2960.0070, subpart 5(A)(1)

3 POTENTIAL FOR SELF-INJURY

Potential for self-injury identified

☒ Yes

☒ No

☒ Unable to determine

☐ Current thoughts / urges

☐ Plan or intent

☐ Recent self-injury

☐ Prior history

☐ Warning signs / acute distress

☐ Access to means

☐ None reported / observed

☐ Other

FINDINGS, RELEVANT HISTORY, PROTECTIVE FACTORS, AND IMMEDIATE SAFETY ACTIONS / REFERRALS

4 CURRENT MEDICATIONS

Currently taking medication(s)

☒ Yes

☒ No

☒ Unknown

List every current medication, including prescriptions, over-the-counter products, supplements, and as-needed medications.

MEDICATION / STRENGTH	DOSE	ROUTE	FREQUENCY	PURPOSE / PRESCRIBER

ALLERGIES / ADVERSE REACTIONS AND MEDICATION ACCESS, VERIFICATION, OR FOLLOW-UP CONCERNS

If additional medication entries are needed, complete and attach an addendum.

RESIDENT HEALTH SCREENING

Minnesota Rules, part 2960.0070, subpart 5(A)(1)

PAGE 3 OF 3

5 MOST RECENT PHYSICIAN AND CLINIC

PHYSICIAN / HEALTH CARE PRACTITIONER NAME

TELEPHONE NUMBER

DATE LAST SEEN (if known)

CLINIC / PRACTICE NAME

CLINIC TELEPHONE NUMBER

FAX (optional)

CLINIC STREET ADDRESS

CITY

STATE

ZIP

6 STAFF OBSERVATIONS AND SIGNATURES

STAFF OBSERVATIONS

Record the resident's general condition and staff's direct observations, including whether the resident appears intoxicated or under the influence of a controlled substance. Note any known or reported history of withdrawal symptoms and describe how those symptoms typically present.

SCREENED BY - PRINTED NAME / TITLE

SIGNATURE / ELECTRONIC SIGNATURE

DATE / TIME