

471-000-221 Instructions for Completing Form DM-5, "Physician's Confidential Report." for the Preadmission Screening Process (PASP)

Use: Form DM-5 is used to secure the physician information needed to determine the kind and amount of medical care needed.

Number Prepared: One copy of Form DM-5 is completed.

Completion: Form DM-5 is completed as follows.

The facility completes these items:

Heading: Enters all the identifying information about the individual.

Item 1: No entry required.

Item 2: Reason for Referral: The effectiveness of information reported on this form depends largely on the phrasing in this section. A definite statement must be entered in this section.

The physician completes these items:

Items 3-15: Enter all appropriate information.

Signature: The physician signs and dates Form DM-5.

Distribution: For a negative screen for a Medicaid-eligible individual, the facility sends Form DM-5 to the nursing facility along with Form DPI-OBRA1. For a positive screen/Level II evaluation, the facility holds Form DM-5 for the OBRA Contractor.

Retention: Form DM-5 is retained for four years.

To view printable form click here: [Physician's Confidential Report](#)

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MANUAL LETTER # 21-2014

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAID SERVICES
471-000-221
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PHYSICIANS CONFIDENTIAL REPORT

Recipient/Payee, Relationship, Address	Name of Patient		
	I.D./Social Security No.	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Admission Date	Eligibility Date	Local Office

Name, Address and Specialty of Examining Physician

1. To the Physician: The individual named above is an applicant for or recipient of assistance. Medical findings which you are asked to report on this form are used to determine eligibility for assistance and to plan for medical care and other services. It is important that your report be specific enough to indicate the kind and extent of disability and the treatment and services required. Attach additional pertinent information including hospital admission/discharge summaries, lab reports, consultative reports/letters, psych. reports and testing, etc.

2. Reason for Referral

	Name - Title/Position	Date
3. Diagnosis (Related to present medical condition):	Date of Onset	Anticipated Duration
Primary _____		
Secondary		
1. _____		
2. _____		
3. _____		

4. Prognosis, Include Rehabilitation Potential:

5. History of Present Illness - Current Medical Symptoms/Conditions (Include pertinent past medical history)

6. Specific Physical Findings (Include pertinent positive and negative findings)

Height _____ Weight _____ Pulse _____ Blood Pressure _____

A. Vision and Hearing

B. Respiratory

C. Gastro-Intestinal

D. Genito-Urinary

E. Cardio-Vascular

F. Musculo-Skeletal

G. Neurological*

*(Findings must be documented if primary diagnosis is Dementia, Alzheimers or related condition)



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DM-5 Rev. 3/08 (58005)
(Previous version 8/99 should be used first)

