<u>LAPEER COUNTY COMMUNITY MENTAL HEALTH</u> **Date Issued** 10/06/2009 **Date Revised** 04/17/12; 8/13/14; 06/25/15; 06/20/23; 07/14/23

CHAPTER	CHA	PTER	SEC	TION	SUBJECT
Health/Medical	03		002		20
SECTION		DESCRIPT	ION		
Health Care		Physical Ex	amina	ations	
WRITTEN BY	REVISE	ED BY		AUTHORIZ	ZED BY
Lisa K. Jolly, B.S.	Sarah V	Vhitehead, R	N,		2 9/14/23
Recipient Rights Officer	BSN			10	- 1.11=3
	Nursing	Supervisor	/	Lauren Em	mons, ACSW
				CEO	

APPLICATION:

⊠CMH Staff	☐Board Members	⊠Provider Network	⊠Employment
			Services Providers
□Employment	⊠Independent	□Students	□Interns
Services Provider Agencies	Contractors		
□Volunteers	⊠Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) documents the decision to perform a physical examination is made by a prescriber.

STANDARDS:

- A. LCCMH prescribers determine and document the need for a physical examination, either at the time of intake or throughout the course of treatment. Physical examinations may be required if there is suspicion or knowledge of a medical condition impacting current or planned mental health or substance use disorder treatment.
- B. Residential, work activity, day activity and recreational therapy persons served are required to have an annual physical examination completed by a physician.

PROCEDURES:

A. Prior to intake, all persons served or their parent/guardian completes the Adult Personal Information Form (LCCMH Form #93) or the Child/Adolescent Personal

CHAPTER	CHAPTER	SECTION	SUBJECT	
Health/Medical	03	002	20	
SECTION		DESCRIPTION		
Health Care		Physical Exam	Physical Examinations	

Information Form (LCCMH Form #94), which queries general health, past health history and current symptoms and conditions.

- B. At the time of the psychiatric evaluation, if the person served was recently discharged from the hospital, a copy of the most recent physical examination is obtained and reviewed by the prescriber.
- C. Nursing Assessment are completed at psychiatric evaluation and annually thereafter and are documented in the Nursing Progress note.
 - Results found outside of accepted parameters are shared with the person served (guardian and/or parent if applicable), the primary case holder, the primary care physician (PCP), and the LCCMH prescriber.
 - The purpose of the Nursing Assessment is to identify health care concerns, provide education regarding identified health care concerns, and to facilitate the integration of treatment with the primary case holder and PCP.
- D. When a physical examination is recommended or required, persons served are referred to their PCP. All returned physical examinations are reviewed by the prescriber and their recommendations documented in the record of the person served.
- E. Residential providers maintain complete health records (medical and dental) for their persons served.
 - 1. Primary case holders are responsible for monitoring health records quarterly, or more frequently as indicated.
 - 2. Copies of the person served physical examination are included in the LCCMH case record, if possible.
- F. Clinicians who note conditions, medications, and/or symptoms which may preclude, effect, or impact the mental health or substance use disorder treatment of a person served in any manner are to seek consultation from a prescriber.

CHAPTER	CHAPTER	SECTION	SUBJECT		
Health/Medical	03	002	20		
SECTION		DESCRIPTION	DESCRIPTION		
Health Care		Physical Exam	Physical Examinations		

EXHIBITS:

Table 1: Blood Pressure Categories Table 2: Vital Signs and processes

SW:Ir

This policy supersedes #10/09036 dated 10/06/2009.

<u>Table 1:</u> This chart reflects adult blood pressure categories defined by the American Heart Association.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90 – 99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
<u>Hypertensive Crisis</u> (Emergency care needed)	Higher than 180	or	Higher than 110

Table 2:

Vital Sign	Infant	Child	Pre-Teen/Teen
	0 to 12 months	1 to 11 years	12 and up
Heart Rate	100 to 160 beats per minute (bpm)	70 to 120 bpm	60 to 100 bpm
Respiration (breaths)	0 to 6 months 30 to 60 breaths per minute (bpm) 6 to 12 months 24 to 30 bpm	1 to 5 years 20 to 30 (bpm) 6 to 11 years 12 to 20 bpm	12 to 18 bpm ¹
Blood Pressure (<u>systolic</u> / <u>diastolic</u>) ¹	0 to 6 months 65 to 90/45 to 65 millimeters of mercury (mm Hg) 6 to 12 months 80 to 100/55 to 65 mm Hg	90 to 110/55 to 75 mm Hg	110 to 135/65 to 85 mm Hg
Temperature	All ages 98.6 F (normal range is 97.4 F to 99.6 F)	All ages 98.6 F (normal range is 97.4 F to 99.6 F)	All ages 98.6 F (normal range is 97.4 F to 99.6 F)

^{*}University of Wisconsin School of Medicine and Public Health*