

**ALL SPACES MUST BE FILLED OUT**

Facility Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Patient's/Resident's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Present Home Address: \_\_\_\_\_

Street

City

State

Zip

Reason for evaluation:  Pre-Admission  12 month  Acute change in patient condition

Other (Describe): \_\_\_\_\_

**MEDICAL REVIEW FINDINGS**

Vital Signs: BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ T: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ in. Weight: \_\_\_\_\_

Primary Diagnosis(s): \_\_\_\_\_

Secondary Diagnosis(s): \_\_\_\_\_

Allergies:  None Known Allergies (list): \_\_\_\_\_

Diet:  Regular  No Added Salt  No Concentrated Sweets  Mechanical Soft  Other: \_\_\_\_\_

Does the resident have dental health concerns requiring treatment or which may impair chewing/eating? No  Yes

If yes, describe: \_\_\_\_\_

Tobacco Use:  PPD/Years: \_\_\_\_\_ Alcohol Use:  Amount/Frequency: \_\_\_\_\_

Recreational Drug Use:  Describe \_\_\_\_\_

**IMMUNIZATIONS**

- Influenza (Date \_\_\_\_\_)
- Pneumococcal Vaccine (Date \_\_\_\_\_)
- Tetanus Vaccine (Date \_\_\_\_\_)

**SCREENINGS**

- Mammogram (Date \_\_\_\_\_)
- Pap Smear (Date \_\_\_\_\_)
- PSA (Date \_\_\_\_\_)
- Colonoscopy (Date \_\_\_\_\_)

**TUBERCULIN TEST** (Required within 30 days prior to admission unless medically contraindicated)  Test is contraindicated

TST1: \_\_\_\_\_ Date placed \_\_\_\_\_ Date Read \_\_\_\_\_ mm

TST2: \_\_\_\_\_ Date placed \_\_\_\_\_ Date Read \_\_\_\_\_ mm

QuantiFERON-TB (QFT): \_\_\_\_\_ Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ mm

Based on my findings and on my knowledge of this patient, I find that the patient \_\_\_\_\_ **IS** \_\_\_\_\_ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

**CONTINENCE**

Bladder: Yes  No  If no, is incontinence managed? Yes  No

Bowel: Yes  No  If no, is incontinence managed? Yes  No

If no, recommendations for management: \_\_\_\_\_

**Patient/Resident Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING (ADL's)**

Activity Restrictions: No  Yes  (describe): \_\_\_\_\_

Dependent on Medical Equipment: No  Yes  (describe): \_\_\_\_\_

Does the resident need the assistance of another person to perform the following?

Ambulate: No  Yes  Intermittent  Continual  Transfer: No  Yes  Intermittent  Continual

Feeding: No  Yes  Intermittent  Continual  Manage Medical Equipment: No  Yes  Intermittent  Continual

**ADDITIONAL SERVICES:**  None (List all that are needed. Attach additional sheet if necessary)

**Reason** **Reason**  
Physical Therapy  \_\_\_\_\_ Speech Therapy  \_\_\_\_\_

Occupational Therapy  \_\_\_\_\_ Other (Specify)  \_\_\_\_\_

Home Care:  Nursing  PCA  HHA  Other (describe) \_\_\_\_\_

**LABORATORY SERVICES:**  None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

**COGNITIVE IMPAIRMENT/MEMORY LOSS**

Based on your examination and/or information received from caregivers, do you recommend the patient be screened and/or tested for dementia or another cognitive impairment? (If yes, indicate who will perform screening/testing below)

No  Yes (describe) \_\_\_\_\_

If yes, testing to be performed by: \_\_\_\_\_

**MENTAL HEALTH ASSESSMENT**

Does the patient have a history of or a current mental disability?  Yes  No

Has the patient ever been hospitalized for a mental health condition?  Yes  No

If Yes, describe: \_\_\_\_\_

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)

No  Yes Describe: \_\_\_\_\_

Comments: \_\_\_\_\_



Patient/Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN CERTIFICATION**

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

- IS    IS NOT   mentally **suited** for care in an Adult Home or Enriched Housing Program.
- IS    IS NOT   medically **suited** for care in an Adult Home or Enriched Housing Program.
- IS    IS NOT   in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.
- IS    IS NOT   in need of 24-hour skilled nursing care.

**LEVEL OF CARE RECOMMENDATION: (see Statement of Purpose)**

- Adult Home/Enriched Housing Program/Assisted Living Residence    Enhanced ALR    Special Needs ALR

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF PURPOSE**

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR) provide 24-hour residential care for dependent adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above.

**ALRs with certification to provide:**

**Enhanced ALR** care may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment, have intermittent nursing needs (less than 24 hours a day); or have chronic, unmanaged urinary or bowel incontinence.

**Special Needs ALR** care may serve people who have a need for a secured environment and/or highly specialized services due to advanced dementia or other special need.