

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ **Date of Exam:** _____

Facility Name: _____ **Date of Birth:** _____ **Sex:** _____

Present Home Address: _____
Street City State Zip

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

MEDICAL REVIEW FINDINGS

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

Primary Diagnosis(s): _____

Secondary Diagnosis(s): _____

Allergies: None or list **Known Allergies:** _____

Diet: Regular No Added Salt No Concentrated Sweets Other: _____

Immunizations: Influenza (Date _____) Pneumococcal Vaccine (Date _____)

TB SCREENING (performed **within 30 days prior to initial admission** unless medically contraindicated)

Test is contraindicated **Test:** TST1 TST2 TB Blood Test (Type) _____ Date _____ Result _____

TST1: Date placed _____ Date Read _____ mm _____ TST2: 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: _____

LABORATORY SERVICES: None

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

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No Yes (describe): _____

Dependent on Medical Equipment: No Yes (describe): _____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent Intermittent Continual
2. Transfer: Independent Intermittent Continual
3. Feeding: Independent Intermittent Continual
4. Manage Medical Equipment: Manages Independently Cannot Manage Independently

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

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: None or if yes, describe _____

Therapies: None Yes (specify): Physical Therapy Speech Therapy Occupational Therapy

Home Care: None Yes (specify): _____ Other (Specify): _____

Is Palliative Care Appropriate/Recommended: No If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? No Yes

If yes, do you recommended testing be performed? No If yes, referral to: _____

If testing has already been performed, date/place of testing if known: _____

MENTAL HEALTH ASSESSMENT (non-dementia)

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

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

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
 No Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- Correctly read the label on a medication container
- Correctly follow instructions as the route, time dosage and frequency
- Correctly ingest, inject or apply the medication
- Measure or prepare medications, including mixing, shaking and filling syringes
- Open the container
- Safely store the medication
- Correctly interpret the label

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with all medications unless physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes No
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

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
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons 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 who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

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):

- Yes** **No** **Is mentally suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/ Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).
- Yes** **No** **Is medically suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).
- Yes** **No** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form: _____ **Date:** _____

Physician Signature: _____ **Date** _____