ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name:	Resident's Name: Date of Exam:				
Facility Name:			Date of Birt	h: Sex:	
Present Home Address	:				
	Street		City	State	Zip
Reason for evaluation:	□ Pre-Admissi	on 🗆 12 month	n □ Acute change in c	ondition Other:	
		MEDICA	L REVIEW FINDINGS		
Vital Signs: BP:	_ Pulse:	Resp:	T: Height: _	ftin. Weight:	
Primary Diagnosis(s):					
Secondary Diagnosis(s):					
Allergies: None or list	t Known Allerg	ies:			
Diet: ☐ Regular ☐ No A	Added Salt 🗆 N	o Concentrated	I Sweets □ Other:		_
Immunizations: Influe	nza (Date)	☐ Pneumococcal Vac	cine (Date	_)
TB SCREENING (perform	med within 30 a	lays prior to in	i itial admission unless	medically contraindicated	a)
☐Test is contraindicate	ed Test: □ TS	ST1 🗆 TST2	□TB Blood Test (Type	e) Date	Result
TST1: Date placed	_ Date Read_	mm	TST2: Date pla	ced Date Read	mm
Based on my findings an or symptoms suggestive	d on my knowled of communicabl	dge of this patie e disease that o	ent, I find that the patier could be transmitted thr	nt IS IS rough casual contact.	NOT exhibiting signs
CONTINENCE					
Bladder: Yes No No Bowel: Yes No No I					
If no, recommendations f	or management	:			
LABORATORY SERVICES: □None					
Lab Test F	Reason/Frequer	псу	Lab Test	Reason/Freque	ncy

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ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

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 ingest, inject or apply the medication
- Open the container
- Safely store the medication

- Correctly follow instructions as the route, time dosage and frequency
- Measure or prepare medications, including mixing, shaking and filling syringes
- Correctly interpret the label

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ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Reside	nt Name:			Date:					
Resident will radministration		nce wit	h <u>all</u> medicat	ions <u>unle</u>	ess physician indicates th	nat resident is capable of self-			
 Does the patient/resident require assistance with medications (see criteria on page 2)? Yes No No No									
Medication	Dosage	Туре	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	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:					
Physic	Physician Signature: Date				

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