ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

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
_____	_____	_____	_____
_____	_____	_____	_____

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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

New York State Department of Health
Division of Assisted Living

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

Resident will receive assistance with <u>all</u> medications <u>unless</u> 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.

<u>PHYSICIAN CERTIFICATION</u>

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** _____