DSS-4449-C1

MEDICAL EVALUATION

Check all that apply: ❑ EH/AH ❑ ALP ❑ Initial ❑ RUG Category Change ❑ 12 Month

This form may be used to verify that an Individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP.

Name:

Facility Name:

Address:

Sex M [ ] F [ ]	Date of Birth	Weight	B/P

Primary Diagnosis**:**

Secondary Diagnosis**:**

Significant medical history and current conditions**:**

CHHA reminder:
assist with oxygen ____ Orders/Hours on: **NA**
Glucometer Testing ____ Freq/Perimeters: **NA**

Continence:
Bladder: ____Yes ____No
Bowel: ____Yes ____No

Needs assistance with self-administration of meds?
_____ Yes _____ No
Allergies: _____ _____

Diet: ____NCS ____NAS ____Regular

Supplement_____

List all current medications (prescription and OTC), including dosage, type, frequency, and method of administration, and note any special instructions: (attach additional sheet if necessary) Please specify reasons for prn /parameters, MD notification. Attach scripts for medications and DME.

1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6.	**14.**
7.	**15.**
8.	**16.**

DNR Continues ____Yes ____No PRI Order (q 6 mos/change in condition) ____Yes ____No
Is the Individual:
Free of communicable disease? ____Yes ____No. If no. describe_____
Able to transfer without assistance? ____Yes ____No. If no. describe_____
Ambulatory without assistance? ____Yes ____No. If no describe_____

Describe Activity Restrictions/Assistance Needed with ADL's (e.g. eating, transferring, toileting):
Eating/escorts _____ Toileting/hygiene _____
Personal care_____ Safety checks: _____Yes ____ No _____Frequency

Describe Current Treatment Plan (e.g. nursing, therapies, labs, etc.): **Supervision of all Medications by Adult Care Facility**

SNV: ALP q6m & PRN Change in Condition. Assess & Evaluate plan of care appropriate to residents clinical needs**.** Supervise and evaluate performance of aide through _____(site) ALP q6mo.
CHHA assistance for personal/escorts, AM/PM 24-hours 7 days a week per care plan.
Summary: _____ Admit/continues to benefit from ALP support services.

MEDICATION EVAULATION (Page 2)

Name: _____

Activities Permitted

1 ☐ Complete bedrest
2 ☐ Bedrest BRP
3 ☐ Up as tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial weight bearing
7 ☐ Independent at home

DME/Other Equipment

A ☐ Crutches
B ☐ Cane
C ☐ O2_____
D ☐ Foley
E ☐ Commode
F ☐ Urinal
G ☐ Attends
H ☐ Shower Chair
I ☐ TEDS/JOBST Stockings
J ☐ Wheelchair
K ☐ Walker
L ☐ No Restrictions
M ☐ Glucometer
N ☐ Other (Specify)

Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
10 ☐ Dyspnea w/Min. Exertion
11 ☐ Other (Specify)

Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

Goals: Maintain optimal level ADL functioning in ALP. Safety optimized by supervised environment.
Rehab: Good potential related to health status.
Discharge: Remain in ALP until increase or decrease level of care defined _____

Is the individual's condition stable? __Yes ____No. If no. describe:_____

Is a Mental Health Evaluation recommended? __Yes ___No. (If yes. See attached form)

Date of Today's Examination:___ _____Recommended Frequency of Medical Exams:_____
(minimum every 6 months for ALP recertification)

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regiments and that the individual is medically appropriate to be cared in an adult home, enriched housing program or an ALP.

Signature:_____**Date:**_____
Physician (required)

Provider telephone number_____

Policy Procedures Reviewed/Revised	
Date: 5/7/02	By:
Date:	By:
Date:	By:

MENTAL HEALTH EVALUATION

"Each mental health evaluation shall be a written and signed report from a psychiatrist, physician, nurse, psychologist or social worker who has experience in the assessment and treatment of mental illness."

Name: _____

Examination Date: _____

1. Is the individual mentally suitable for residence in an Adult Care Facility?
   ____Yes _____ No _____

2. Does the individual require placement in a mental health care facility?
   _____ Yes _____ No _____

3. Significant mental health history and current conditions:
   (Please include suggestions and follow-up treatment plan).

   _____

   _____

   _____

4. Prescribed Medication:

   _____
   _____

I have conducted a face-to-face examination of this individual.

_____ _____

Signature Date