

# Caton Merchant HOUSE

## ASSISTED LIVING FACILITY REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days prior to the date of admission. Report is to be kept as part of the person's permanent record.)

NAME \_\_\_\_\_ DATE OF PHYSICAL EXAM \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER ( ) \_\_\_\_\_

Does the patient have a DNR?    YES            NO (If yes, please provide form.)

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ PULSE: \_\_\_\_\_ RESP: \_\_\_\_\_

History of MRSA?    YES            NO            Date of last Influenza Vaccine: \_\_\_\_\_

History of VRE?    YES            NO            Date of last Pneumonia Vaccine: \_\_\_\_\_

Significant Medical History:                      Zostravox Vaccine:    YES            NO

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Physical Condition, including systems review as is medically indicated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (food, medicine or other)

\_\_\_\_\_  
\_\_\_\_\_

Is this person:

\_\_\_ Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate)

\_\_\_ Non-ambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person)

Name:

Does this person have any of the following conditions or care needs?

CONDITION/CARE NEED	YES	NO	COMMENT
Ventilator Dependency			
Dermal Ulcers III and IV			If stage III is ulcer healing?
Intravenous therapy or injections directly into the vein			If intermittent therapy please note and indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission.			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is person capable of independently feeding himself and caring for the tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Name: \_\_\_\_\_

Diagnosis or significant problems:

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Recommendations for care:

In your opinion, is this person able to administer his/her own medications? YES NO

Medications: (Prescription, OTC, and Dietary Supplements)

Name of medication, route, dosage, strength	How often med is to be given	Diagnosis, condition, or specific indication

Diet:  Regular Diet  Regular Diet as tolerated

Therapy:

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In your opinion, can this person's needs be met in an adult care residence? YES NO

I am aware that adult care residences are not licensed to provide nursing and convalescent care and are not medical facilities.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Name: \_\_\_\_\_

If there are observed behaviors or patterns of behavior indicative of mental illness, mental retardation, substance abuse, or behavioral disorders, an evaluation of the individual is to be conducted by a qualified mental health professional.

In the past six months has this person exhibited any of the following behaviors or conditions?:

Behavior or Condition	Yes	No	Comments
One or more acts of aggression against self, others, or property that resulted in the Resident being hospitalized, jailed, forced to leave a residents, or retained by the facility but managed using emergency measures			
Alcohol or drug abuse			
Noncompliant with psychotropic medications to the extent that intervention by a qualified mental health professional was required to prevent or reduce the risk of decompensation			
Disturbance in thinking, reasoning, and judgment that placed the resident or others at risk for harm			
Bizarre or maladaptive behavior such as reacting to irrational beliefs, visual or auditory hallucinations or engaging in behaviors such as pacing, rocking, mumbling to self, speaking incoherently, avoiding social interactions			
Significant dysfunction in two or more of the following areas: <input type="checkbox"/> problem-solving <input type="checkbox"/> vocation <input type="checkbox"/> personal care <input type="checkbox"/> leisure <input type="checkbox"/> independent living <input type="checkbox"/> education <input type="checkbox"/> community awareness <input type="checkbox"/> self-direction <input type="checkbox"/> self-preservation			
Any other condition for which an assessment is recommended			

In your opinion, does this person need further evaluation by a Qualified Mental Health Professional?

YES            NO

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

Signature: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

(Please print or type Physician's Name here)

Name: \_\_\_\_\_

## REPORT OF TUBERCULOSIS SCREENING EVALUATION

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

1. Date and result of most recent Mantoux tuberculin skin test: Date: \_\_\_\_\_

mm of induration: \_\_\_\_\_

2. Check here if previously positive and above information unknown \_\_\_\_\_

3. Check here if exhibiting TB-like symptoms \_\_\_\_\_

4. If TB skin test is 10 mm or greater (5 mm in the HIV infected), previously positive or if TB-like symptoms exist, *respond to the following*:

a. Date of last chest x-ray evaluation: \_\_\_\_\_

b. Is chest x-ray suggestive of active TB? YES NO

c. Were sputum smears collected and analyzed for the presence of Acid Fast Bacilli (AFB)? YES NO

d. If 4c is YES, were three consecutive smears negative for AFB? YES NO

5. Based on the above information is this individual free of communicable TB? YES NO

6. Name of licensed physician, physician's designee or local health department official completing the evaluation:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone Number

7. Signature of licensed physician, physician's designee or local health department official completing the evaluation:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

In your opinion, this person qualifies under the IRS "Medical and Dental Expenses" Publication 502 v. 2007 as being "chronically ill" either by:

Loss of functional capacity makes person unable to perform at least two activities of daily living without substantial assistance from another individual for a period of at least 90 days. Activities of daily living are eating, toileting, transferring, bathing, dressing, continence, and medication administration.

YES

NO

**AND/OR**

Person requires substantial supervision to be protected from harm to self, health and safety due to cognitive impairment.

YES

NO

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_