Senior HealthCare, Inc.

Phone: 301-754-2544; Fax: 301-754-2588

Resident Name: _____ Date of Birth: _____
Date completed _____

Health Care Practitioner Physical Assessment

This form is to be verified by signature for accuracy by a physician, verified nurse practitioner, Registered Nurse or Certified Nurse Midwife

Please note the following before filling out this form – An applicant for admission who needs any of the following services may not move into an assisted living facility: (1) more than intermittent nursing care; (2) treatment for stage three or four skin ulcers; (3) ventilator services; (4) skilled monitoring, testing and aggressive adjustment of medications and treatment where there is the presence of or risk for, a fluctuation acute condition; (5) monitoring of chronic medical conditions that are not controllable through readily available medications and treatments; (6) treatment for active reportable communicable disease; or (7) treatment for a disease or condition which requires more than contact isolation. (Exception: individuals who (a) are in a specialized program for HIV/AIDS which the department has approved or, (b) are under the care of a general hospice program.

1. Current Medical and Psychiatric History [Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc. Within the past 6 months]:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, and physical functional and psychological condition or changes, over the years:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3. Allergies [List any allergies or sensitivities for food, medications or environmental factors, and if known, the nature of the problem (rash, anaphylactic reaction, GI symptoms, etc.)Please enter medication allergies here and also in item#12 for medication allergies]:

_____
_____

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4. Communicable illnesses: Is the individual free from communicable TB and any other active reportable airborne communicable disease(s)? (Check one)_____Yes _____No- If' No", then indicate the communicable disease:
_____
Which tests were done to verify the individual is free from active TB:
PPD Date_____ Result_____ mm
Chest X-Ray (if PPD positive or unable to administer a PPD) Date_____
Result_____

5. History of: [Does individual have any history of current problem related to abuse of prescription, non –prescription, OCT, illegal drugs, alcohol, or inhalants, etc.?]

a) Substance: OTC, non-prescription medication abuse or misuse (check one)
   1. Recent (last 6 months _____Yes _____No
   2. History _____ Yes _____No
b) Abuse or misuse of prescription medication or herbal supplements
   1. Currently _____Yes _____No
   2. Recent (last 6 months _____Yes _____No
c) History of non-compliance with prescribed medication
   1. Currently _____Yes _____No
   2. Recent (last 6 months _____Yes _____No
d) Describe misuse or abuse: _____
_____

6. Risk factor for falls an injury. Identify any conditions about this individual that increase their risk of falling or injury (check that apply): ____ orthostatic hypo-tension _____ osteoporosis _____gait problem
_____ impaired balance ____ confusion _____ parkinsonism _____ foot deformity _____ pain
_____assistive devices ____ other (explain)_____

7. Skin condition(s) Identify any current or history of ulcers, rash, skin tears with any standing treatment orders also noted in item#12 C, easy bruising, etc. and their causes:
_____
_____

8. Sensory impairments affecting functioning (check all that apply):

a) Hearing: Left ear: _____Adequate _____Poor _____Deaf _____ Uses corrective aid
   Right ear: _____Adequate _____Poor _____Deaf _____ Uses corrective aid
b) Vision: Left eye _____Adequate _____Poor _____Uses corrective lenses ____Blind
   Right eye _____Adequate _____Poor _____Use corrective Lenses ____Blind
c) Temperature sensitivity): _____ Normal Decreased in sensation to: ____ heat ____cold

9. Current nutritional status: Height _____inches weight _____ lbs.

a) Any weight change gain or loss in past 6 months? _____ Yes _____ No
b) How much weight change? _____ lbs. in the past ____ months (check one) _____ loss ____ gain
c) Monitoring necessary? _____ Yes _____ No
If items a), b), c) is checked: Explain how and at what frequency the monitoring is to occur_____
_____
d) Is there evidence of malnutrition or a risk for under nutrition? _____Yes _____ No
e) Is there evidence of dehydration or a risk for dehydration? _____Yes _____ No
f) Monitoring of nutritional or hydration status necessary? _____ Yes _____ No
If items d), and or e) are checked, explain how and at what frequency the monitoring is to occur _____
_____
_____
g) Does any individual have medical or dental conditions affecting (check all that apply):
_____chewing _____swallowing ____Eating _____Pocketing food _____Gastronomy Tube fed

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h) Note any special therapeutic diet e.g. sodium restricted, renal, calorie or sugar restricted):
_____
_____

i) Modified consistency (e.g. Pureed, Mechanical soft or thickened liquids):
_____ plated guard _____ special cups/glass
j) Monitoring necessary _____ Yes _____ No
If items g), h), or i) are checked, please explain how and at what frequency:
_____
_____
_____

10. Cognitive/Behavioral Status

a) Is there evidence of dementia (check one) _____ Yes _____ No
b) Has the individual undergone evaluation for dementia (check one) _____ Yes ____No
c) Diagnosis (cause[s] of dementia) ____ Alzheimer's _____ Multi infarct /Vascular _____ Parkinson
Other _____
d) Mini Mental Status Exam (if tested) Date _____ Score _____
e) Instructions for the following items: for each item circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details

Item 10 e)	A	B	C	D	Comments
I. Cognition a) Disorientation	Never	Mild	Moderate	Severe	
b) Recall Impairment (Recent / distant events)	Never	Occasional	Regular	Continuous	
c) Impaired judgment	None	Mild	Moderate	Severe	
d) Hallucinations	Never	Occasional	Regular	Continuous	
e) Delusions	Never	Occasional	Regular	Continuous	
II. Communication a) Receptive/Expressive Aphasia	None	Mild	Moderate	Severe	
III. Mood and Emotions a) Anxiety	Never	Occasional	Regular	Continuous	
b) Depression	None	Mild	Moderate	Severe	
IV. Behavior a) Unsafe Behavior	Never	Occasional	Regular	Continuous	
b) Dangerous to self or others	Never	Occasional	Regular	Continuous	
c) Agitation	Never	Occasional	Regular	Continuous	

f) Health care decision making capacity:

Based on the preceding review of functional capabilities and physical and cognitive status and limitations indicate this individual's highest level of ability to make health care decision:

_____a) probably can make higher level decisions (such as whether to undergo or withdraw life sustaining treatments) that require understanding the nature, probable consequences and burdens and risks of proposed treatment.
_____b) probably can make limited decisions that require simple understanding
_____c) probably can express agreement with decisions proposed by someone else
_____d) cannot effectively participate in any kind of health care decision – making

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11. Ability to self administer medications
Based on the preceding review of functional capabilities, and physical and cognitive status and limitation, rate this individuals ability to take his/her own medications safely and appropriately:

_____a) independently without assistance
_____b) can do so with physical assistance, reminders or supervision only
_____c) need to have medication administered by someone else

_____ Date _____
Print Name

_____
Signature of license category of health care practitioner

Resident Name _____Date of Birth_____
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PRESCRIBERS MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Birth Date: _____ Allergies: _____

Note: Does resident require medications crushed or in liquid form? Please indicate in 12 a) with medication order. If the medication is not to be crushed please indicate.

12a) Medication(s) including PRN, OTAC, herbal and dietary supplements	**12b)** All related diagnoses/ Problems/ Conditions	**12c)** Treatments (include frequency and any instructions about when to call MD)	**12d)** Related testing or monitoring
Include dosage, route (p. o, etc.) frequency, duration (if limited)	Please include all the diagnoses that are currently being treated	Please link diagnosis, condition or problems as noted in prior sections	I Include frequency and any instructions to notify MD

Prescriber's signature_____ Date _____

Office address _____ Phone # _____

_____ Date _____

Signature of RN who has reviewed and reported the above to family, resident and pharmacy dispensed medications supplied at time of review.

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