

**Resident Health Assessment for**

**Assisted Living Facilities**

**To Be Completed By Facility:**

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| --- |
| **Resident Information** |
| Resident Name:       | DOB:       |
| Authorized Representative (if applicable):       |

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| --- |
| **Facility Information** |
| Facility Name:       | Telephone Number:       |
| Street Address:       | Fax Number:       |
| City:       | County:       | Zip:       |
| Contact Person:       |

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| **INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS:****After completion of all items in Sections 1 and 2 (pages 1 - 3), return this form to the facility at the address indicated above.** |

**Section 1. Health Assessment**

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| NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination. |

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| --- | --- | --- |
| **Known Allergies:**       | **Height:**       | **Weight:**       |
| **Medical History and Diagnoses:**       |
| **Physical or Sensory Limitations:**       |
| **Cognitive or Behavioral Status:**       |
| **Nursing/Treatment/Therapy Service Requirements:**       |
| **Special Precautions:**       | **Elopement Risk:****Yes: [ ]  No: [ ]**  |

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| **Resident Information** |
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| Authorized Representative (if applicable):       |

**Section 1. Health Assessment (continued)**

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| NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination. |

1. **To what extent does the individual need supervision or assistance with the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Key** | **I = Independent**Staff does not assist at all | **S = Needs Supervision**Staff provide cueing or prompting, but resident completes the action | **A = Needs Assistance**Staff provide physical assistance with the resident’s participation | **T = Total Care**Staff completes the action for the resident |

**Indicate by a checkmark (✓) in the appropriate column below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ACTIVITIES OF DAILY LIVING:** | **I** | **S** | **A** | **T** |
| **Ambulation** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Bathing** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Dressing** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Eating** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Self-Care (grooming)** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Toileting** | [ ]  | [ ]  | [ ]  | [ ]  |
| **Transferring** | [ ]  | [ ]  | [ ]  | [ ]  |

1. **Special Diet Instructions:**

**Regular** [ ]  **Calorie Controlled** [ ]  **No Added Salt** [ ]  **Low Fat/Low Cholesterol** [ ]

**Other (**specify, including consistency changes such as puree):

1. **Does the individual have any of the following conditions/requirements?**

|  |  |  |
| --- | --- | --- |
| **STATUS** | **YES** | **NO** |
| **A communicable disease, which could be transmitted to other residents or staff?** | [ ]  | [ ]  |
| **Bedridden?** | [ ]  | [ ]  |
| **Any stage 2, 3, or 4 pressure sores?** | [ ]  | [ ]  |
| **Pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.)** | [ ]  | [ ]  |
| **Require 24-hour nursing or psychiatric care?** | [ ]  | [ ]  |

1. **In your professional opinion, can this individual’s needs be met in an assisted living facility, which is not a medical, nursing, or psychiatric facility? Yes** [ ]  **No** [ ]

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**Section 2. Self-Care and General Oversight Assessment - Medications**

1. **Attach a listing of all currently prescribed medications, including dosage, directions for use, and route.**
2. **Does the individual need help with taking his or her medications (meds)? Yes** [ ]  **No** [ ]

**If YES, place a checkmark (✓) in front of the appropriate box below:**

|  |  |
| --- | --- |
| [ ]  **Needs Assistance With Self-Administration*** This allows unlicensed staff to assist with nasal, ophthalmic, oral, otic, and topical medications.
 | [ ]  **Needs Medication Administration*** Not all assisted living facilities have licensed staff to perform this service.
 |
| [ ]  **Able To Self-Administer Medications** * Resident does not need staff assistance
 |  |

1. **Additional Comments/Observations** (use additional pages, if necessary)**:**

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| **NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION.** |

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| **Name of Examiner** (please print)**:**       |
| **Medical License Number:**       |
| **Title of Examiner** (check one)**:** [ ]  **MD** [ ]  **DO** [ ]  **APRN** [ ]  **PA** |
| **Telephone Number:**       |
| **Address of Examiner:**       |
| **Signature of Examiner:** | **Date of Examination:**       |