



Resident/Patient Name: \_\_\_\_\_

Is the individual free of communicable disease? Yes No If no, describe: \_\_\_\_\_

**Does the individual require supervision and/or assistance by aide with:**

bathing: No If yes, is it?: intermittent:  constant

grooming: No If yes, is it?: intermittent:  constant

dressing: No If yes, is it?: intermittent:  constant

eating: No If yes, is it?: intermittent:  constant

transferring: No If yes, is it?: intermittent:  constant

ambulation: No If yes, is it?: intermittent:  constant

toileting: No If yes, is it?: intermittent:  constant  \*Such that it requires toileting program 24 hours/7 days per week to maintain continence?

Describe any additional activity restrictions/needs: \_\_\_\_\_

Describe Current Treatment Plan (e.g., nursing, therapies, etc.): \_\_\_\_\_

Is Palliative Care appropriate/recommended?: Yes No If yes, describe services: \_\_\_\_\_

Is the individual's condition stable? Yes No If no, describe: \_\_\_\_\_

**Cognitive Impairment/Memory Loss (including dementia)**

Does the individual have/show signs of dementia or other cognitive impairment? Yes No If yes, describe: \_\_\_\_\_

If yes, do you recommend testing be performed? Yes No If yes, describe: \_\_\_\_\_

If testing has already been performed, date/place of testing if known: \_\_\_\_\_

**Mental Health Assessment (non-dementia)**

Does the individual have a history, current condition or recent hospitalization for mental disability?

Yes No If yes, describe: \_\_\_\_\_

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral? Yes No \_\_\_\_\_

Date of Today's Examination \_\_\_\_\_ Recommended frequency of Medical Exams \_\_\_\_\_

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.

Physician Signature (required) \_\_\_\_\_ Date \_\_\_\_\_

Nurse Practitioner, Physician or Specialist's Assistant Signature \_\_\_\_\_ Date \_\_\_\_\_