MEDICAL EVALUATION and PHYSICIAN ORDERS

Instructions:

This form supplements the Uniform Assessment System for New York (UAS-NY) Community Assessment and is 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.

Check all that apply:

AH ___
EHP ___
ALP ___

Initial Eval ___
RUG Category Change ___
Change of Condition/Medical Eval ____
6 month Eval_____
12 month Eval____

Resident Name:_____

Facility Name: _____

Address: _____

Medical Evaluation:

Date of Birth: _____ **Weight:** _____ **BP:** _____ **Diet:** _____

Significant medical history and current conditions: _____

_____

_____

Is the individual free of communicable disease? ___ **Yes** ___ **No**

If no, describe: _____

_____

_____

Describe Activity Restrictions/Assistance Needed with ADLs (e.g., eating, transferring, toileting):

_____

_____

_____

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

_____

_____

_____

Is a Mental Health Evaluation recommended? ____ Yes ____ No

Diagnosis/Conditions not documented in the UAS-NY Community Assessment:

_____

_____

Medications not documented in the UAS-NY Community Assessment:

Medication	Indication(s) or Special Instructions	Dosage	Frequency	Method of Administration

PHYSICIAN CERTIFICATION

Date of Today's Examination _____ Recommended **Frequency of Medical Exams** _____

I certify that I have reviewed and agree with the UAS-NY Community Assessment dated _____and that the uniform assessment and the information provided on this form accurately describe the individual's medical and mental health conditions, 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.

Signature: _____ **Date:** _____
Nurse Practitioner, Physician or Specialist's Assistant

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