New York State Department of Health
Division of Home and Community Based Services

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Facility Name: ____ **Date of Exam:** _____________

Patient's/Resident's Name: _____________________________________ Date of Birth:___________ Sex:_________

Present Home Address: ____
Street

____
City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in patient condition

☐ Other (Describe): ____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _______ Pulse:_____ Resp: _______ T: _______ Height: _____ft _____in. Weight: _______

Primary Diagnosis(s): ____

Secondary Diagnosis(s): ____

Allergies: ☐ None Known Allergies (list)**:** ____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Mechanical Soft ☐ Other: ___________

Does the resident have dental health concerns requiring treatment or which may impair chewing/eating? No ☐ Yes ☐

If yes, describe:____

Tobacco Use: ☐ PPD/Years: _____________________ Alcohol Use**:** ☐ Amount/Frequency:____________________

Recreational Drug Use: ☐ Describe____

IMMUNIZATIONS

☐ Influenza (Date_____________)

☐ Pneumococcal Vaccine (Date_____________)

☐ Tetanus Vaccine (Date_____________)

SCREENINGS

☐ Mammogram (Date_____________)

☐ Pap Smear (Date_____________)

☐ PSA (Date_____________)

☐ Colonoscopy (Date_____________)

TUBERCULIN TEST (*Required within 30 days prior to admission unless medically contraindicated)* ☐Test is contraindicated

☐ TST1:__________Date placed __________Date Read __________mm

☐ TST2:__________Date placed __________Date Read __________mm

☐ QuantiFERON-TB (QFT):__________Date Placed __________Date Read __________mm

Based on my findings and on my knowledge of this patient, I find that the patient _______ **IS** _______ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:____

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ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe):________________________

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):________________________

Does the resident need the assistance of another person to perform the following?

Ambulate: No ☐ Yes ☐ Intermittent ☐ Continual ☐ Transfer: No ☐ Yes ☐ Intermittent ☐ Continual ☐

Feeding: No ☐ Yes ☐ Intermittent ☐ Continual ☐ Manage Medical Equipment: No ☐ Yes ☐ Intermittent ☐ Continual ☐

ADDITIONAL SERVICES: ☐None (List all that are needed. Attach additional sheet if necessary)

	Reason		**Reason**
Physical Therapy ☐	______________	Speech Therapy ☐	______________
Occupational Therapy ☐	______________	Other (Specify) ☐	______________

Home Care: ☐ Nursing ☐ PCA ☐ HHA ☐ Other (describe) ________________________

LABORATORY SERVICES: ☐None

Lab Test	**Reason/Frequency**	**Lab Test**	**Reason/Frequency**

COGNITIVE IMPAIRMENT/MEMORY LOSS

Based on your examination and/or information received from caregivers, do you recommend the patient be screened and/or tested for dementia or another cognitive impairment? (If yes, indicate who will perform screening/testing below)

☐ No ☐ Yes (describe) ________________________

If yes, testing to be performed by:________________________

MENTAL HEALTH ASSESSMENT

Does the patient have a history of or a current mental disability? ☐ Yes ☐ No
Has the patient ever been hospitalized for a mental health condition? ☐ Yes ☐ No

If Yes, describe: ________________________

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)

☐ No ☐ Yes Describe: ________________________

Comments: ________________________

____

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Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- Correctly read the label on a medication container
- Correctly follow instructions as the route, time dosage and frequency
- Correctly ingest, inject or apply the medication
- Measure or prepare medications, including mixing, shaking and filling syringes
- Open the container
- Safely store the medication
- Correctly interpret the label

MEDICATIONS: (List all prescription, OTC medications, supplements and vitamins. Attach additional sheet if necessary.)

Medication	Dosage	Type	Frequency	Route	Diagnosis	Prescriber (name of MD/NP)	Needs assistance with administration
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

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Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up:___________________________________
____
____

PHYSICIAN CERTIFICATION

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐**IS** ☐ **IS NOT** mentally **suited** for care in an Adult Home or Enriched Housing Program.

☐**IS** ☐ **IS NOT** medically **suited** for care in an Adult Home or Enriched Housing Program.

☐**IS** ☐ **IS NOT** in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.

☐ **IS** ☐ **IS NOT** in need of 24-hour skilled nursing care.

LEVEL OF CARE RECOMMENDATION: (see Statement of Purpose)

☐ Adult Home/Enriched Housing Program/Assisted Living Residence ☐ Enhanced ALR ☐ Special Needs ALR

Name/Title of individual completing form:____ Date:________

Physician Signature: ____ **Date** ______________________

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR) provide 24-hour residential care for dependent adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above.

ALRs with certification to provide:

Enhanced ALR care may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment, have intermittent nursing needs (less than 24 hours a day); or have chronic, unmanaged urinary or bowel incontinence.

Special Needs ALR care may serve people who have a need for a secured environment and/or highly specialized services due to advanced dementia or other special need.