DSS-4449C (Rev. 4/97, 05/13, 9/13)

ALP MEDICAL EVALUATION

Check all that apply: ❑ AH ❑ EHP ❑ ALP ❑ Initial ❑ Rug Category Change ❑12 month ❑ Other

❑ UAS-NY Summary Report is attached for RUG Category Change, 12 month and other assessments

This form may be 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.

Resident/Patient Name: _____ Date of Birth: _____

Facility Name: _____ Address: _____

_____

Sex: Male ❑ Female ❑ **Weight:** _____ **Blood Pressure:** _____

Primary Diagnosis/Prognosis:

Secondary Diagnoses/Prognosis:

Significant medical history & current conditions:	**Continence:** Bladder: ❑ Yes ❑ No Bowel: ❑ Yes ❑ No	**Allergies: KNA ❑**
Needs assistance with self-administration of medications? ❑Yes ❑No	**Type of Diet:** Regular ❑ NSA ❑ NCS ❑ Other: (Explain) ❑	

List all current medications (prescription and OTC, including dosage, type, frequency and method of administration and note special instructions: (attach additional sheets if necessary signed and dated by Physician)

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

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