MEDICAL EVALUATION FORM

Check all that apply: ☐ AH ☐ EHP ☐ ALP ☐ Initial ☐ RUG Category Change ☐ 12 Month

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 individua's needs can be met in an ALP.

Facility Name: _____

Name: _____ Date of Birth: _____/_____/____

Address: _____

City: _____State:_____Zip:_____

Sex: ☐ Male ☐ Female Weight: _____ Blood Pressure: _____

Primary Diagnosis:
Secondary Diagnosis:
Significant Medical History and Current Conditions:
Needs Assistance with self-administration of meds? ☐ Yes
Continence:
Bladder: ☐ Yes ☐ No Bowel ☐ Yes ☐ No

Diet:	Allergies:

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

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

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Is the individual:

Free of communicable disease?	☐ Yes ☐ No	If no, describe:
Able to transfer without assistance?	☐ Yes ☐ No	If no, describe:
Ambulatory without assistance?	☐ 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 the Individuals condition sable? ☐ Yes ☐ No If no, Describe:

_____

_____

Does the individual have a history, current condition or recent hospitalization for mental disability? ☐ Yes ☐ No

If Yes, Describe:_____

Is a Mental Health Evaluation recommended? ☐ Yes ☐ No

Date of Examination: _____ Recommended frequency of Medical Exams:_____

I certify that I have accurately described the individuals 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

_____ Date: _____

Signature – Nurse Practitioner, Physician or Specialist Assistant

_____ Date: _____

Signature – Physician (Required)