

NAME: _____ D.O.B.: _____

MEDICAL DIAGNOSES (include developmental diagnoses if applicable): _____

PSYCHOLOGICAL HISTORY: _____

HEALTH HISTORY: _____

History of falls? no yes, explain: _____

History of wandering? no yes, explain: _____

PHYSICAL EXAM:

WEIGHT: _____ HEIGHT: _____ BLOOD PRESSURE: _____ T. _____ P. _____ R. _____

EARS/HEARING

- Good Partially deaf Completely deaf
- Limited (must speak loudly) Aid: R L

TEETH _____

SKIN _____

HEART _____

ABDOMEN _____

EXTREMITIES _____

COGNITIVE FUNCTION: Normal Impaired
If impaired: mild moderate severe

EYES/VISION

- Good Adequate Limited Vision Blind
- Uses Aid Unable to read

Glaucoma: yes no

Cataract surgery: Dates: R _____ L _____

NOSE/THROAT _____

SCARS _____

LUNGS _____

HERNIA _____

PHYSICAL IMPAIRMENTS _____

PRESCRIPTION MEDICATIONS: List all medications, including route and dosage

*NOTE: PRN medications *must* include indications/instructions

MEDICATION ALLERGIES: _____

MEDICATION ADMINISTRATION (please indicate):

Self Administered

Assistance with
Self Administration

Requires Administration by
Licensed Professional



IF ASSISTANCE IS REQUIRED WITH SELF-ADMINISTRATION OF MEDICATIONS, THEN (Check all applicable)

- REMINDER
- VERIFY DIRECTIONS
- OPEN CONTAINER
- OBTAIN MEDICATION FROM LOCKED AREA
- REMOVING ORAL/TOPICAL MEDICATIONS & ASSIST IN APPLYING/CONSUMPTION
- REMINDER TO ORDER MEDICATION

IMMUNIZATION HISTORY: Please indicate if the individual has received the following vaccinations.

Pneumovax: Yes ___ No ___ Date of vaccination: ___/___/___
Influenza (Flu): Yes ___ No ___ Date of vaccination: ___/___/___
Tetanus: Yes ___ No ___ Date of vaccination: ___/___/___

(Complete Reverse Side)

FUNCTIONAL ASSESSMENT:

ACTIVITIES OF DAILY LIVING	INDEP	NEEDS SUPERV	NEEDS ASSIST
AMBULATING			
EATING			
TOILETING			
NAIL CARE			
BATHING			
GROOMING			
TRANSFERRING			
DRESSING			
ORAL HYGIENE			
HAIR CARE			

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	INDEP	NEEDS SUPERV	NEEDS ASSIST
USING TELEPHONE			
PREPARING OWN MEALS			
ACQUIRING/ USING PUBLIC/ PRIVATE TRANSPORTATION			
HOUSEWORK			
SHOPPING			
LAUNDERING			
HEAVY CHORES			
MANAGING FINANCIAL / LEGAL AFFAIRS			
YARD WORK/ MAINTENANCE			

TYPE OF CARE OR SERVICE INDIVIDUAL REQUIRES BASED ON THE FUNCTIONAL ASSESSMENT

- Independent
 Minimal Assistance
 Moderate Assistance
 Maximum Assistance

DOES THE INDIVIDUAL HAVE APPARENT SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE WHICH IS LIKELY TO BE TRANSMITTED TO OTHER RESIDENTS OR STAFF? YES NO

DOES THIS INDIVIDUAL REQUIRE 24 HOUR NURSING SUPERVISION? YES NO

Explain: _____

DOES THE INDIVIDUAL NEED SKILLED NURSING SERVICES?

(Skilled nursing services other than administration of medication, supervision of special diets and application of dressings, may only be provided on a part-time intermittent basis (< 8 hours/day, < 40 hours / week) for no more than 120 days in any 12 month period):

NO YES IF YES, TYPE, AMOUNT, FREQUENCY, DURATION:

DIET REQUIREMENTS:

- REGULAR
 REDUCED OR NO SIMPLE SUGAR FOOD REGIMENS
 NO ADDED SALT FOOD REGIMENS
 OTHER _____ Please Explain: _____

Food Allergies: _____

TUBERCULOSIS SCREENING: MANTOUX TESTING ORDER

Physician: By checking either option and signing the health assessment, you will be giving the **Retirement Community** an order to complete Mantoux TB skin testing for this resident.

- _____ 2 STEP: 5 T.U. PPD intradermally x 1, if non-significant, repeat dose on 7th day.
 _____ 1 STEP: 5 T.U. PPD intradermally x 1, * record of a 2 step or single step Mantoux TB skin test **within one year**, is required if checking this option.
 _____ NO - Known Reactor, NEED DOCUMENTATION OF A CHEST X-RAY WITHIN PREVIOUS THIRTY DAYS,
 DATE OF CHEST X-RAY ___ / ___ / ___

I AM AUTHORIZING THE CONTINUED REFILL OF ALL THE CURRENTLY PRESCRIBED MEDICATIONS UNTIL THIS RESIDENT'S NEXT SCHEDULED APPOINTMENT.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

EXAMINER NAME: _____
 ADDRESS OF EXAMINER: _____
 PHONE: _____

PLEASE RETURN COMPLETED FORM TO:
 Berea Lake Towers
 3 Berea Commons
 Berea, Ohio 44017
 440-243-9050 FAX: 440/243-9178
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