

Healthcare Facility Regulation Division
PHYSICIAN'S MEDICAL EVALUATION FOR ASSISTED LIVING

NAME OF PATIENT		DOB		HEIGHT
PRESENT ADDRESS				WEIGHT
CITY	STATE	ZIP	TELEPHONE	
REASON FOR EVALUATION: <input type="checkbox"/> Pre-Admission <input type="checkbox"/> Annual <input type="checkbox"/> Possible change in patient's condition <input type="checkbox"/> Other (Describe) _____				
1. Current Diagnosis(es)				
2. Physical Limitations				
3. Mental Health Limitations				
4. Treatment/Therapies (Describe medical services or nursing care or treatment needed.)				
5. Supportive Services Needed				
6. Allergies				
7. DIET INSTRUCTION:				
<input type="checkbox"/> Regular <input type="checkbox"/> No added table salt <input type="checkbox"/> No concentrated sweets <input type="checkbox"/> Other _____				
8. STATUS OF THE FOLLOWING:				
AMBULATING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help <input type="checkbox"/> Bedridden	BATHING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	DRESSING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	EATING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Tube feeding	
GROOMING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	SKIN INTEGRITY <input type="checkbox"/> No pressure sores <input type="checkbox"/> Stage one <input type="checkbox"/> Stage two <input type="checkbox"/> Stage three <input type="checkbox"/> Stage four Location _____ _____	TOILETING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Hygiene assistance <input type="checkbox"/> Adult briefs <input type="checkbox"/> Catheter care assistance <input type="checkbox"/> Ostomy	TRANSFERRING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	
RESTRAINTS <input type="checkbox"/> Requires no restraints <input type="checkbox"/> Requires chemical restraints <input type="checkbox"/> Requires physical restraints Type _____ Type _____				
9. CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW.				
a. The individual HAS HAS NOT received screening for TB and the individual HAS DOES NOT HAVE signs and/or symptoms of infectious diseases which are likely to be transmitted to other residents or staff. TB SCREENING INFORMATION: Date: _____ Results: _____				
b. The individual's behavior DOES DOES NOT pose a danger to self or others. If DOES, please explain. If medications are necessary to control behavior, please explain. _____				

c. The individual **DOES** **DOES NOT** require assistance from staff during the night. If assistance is required, please explain.

d. The individual **DOES** **DOES NOT** require 24 hour nursing supervision.

e. The individual **DOES** **DOES NOT** require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. **MEDICATIONS:** List all medications including over the counter medications, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, i.e. parameters for use.

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION	
				YES	NO

MEDICAL CERTIFICATION SIGNATURE REQUIRED.

Assisted living facilities/personal care homes **ARE NOT permitted** under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: _____ NO: _____

COMMENTS:

SIGNATURE OF PHYSICIAN, PA OR NP:	DATE:
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PRINTED NAME OF PHYSICIAN, PA OR NP	GEORGIA LICENSE #
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ADDRESS OF PHYSICIAN, PA OR NP

CITY	STATE	ZIP CODE
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PLEASE RETURN COMPLETED FORM TO:

CONTACT PERSON	FACILITY NAME
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ADDRESS	PHONE:
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CITY	STATE	ZIP CODE
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