Resident Health Assessment for Assisted Living Facilities

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Facility Information			
Facility Name:	SPRINGWATER MEMORY CARE	Telephone Number: (352) 385-9871	
Street Address:	2858 LIGHTHOUSE SHORE WAY	Fax Number: (352) 385-9991	
City:	MOUNT DORA	County: LAKE	Zip: 32757
Contact Person:	AMY EUBANKS, DIRECTOR OF NURSING		

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS:
After completion of all items in Sections 1 and 2 (pages 1 - 3), return this form to the facility at the address indicated above.

Section 1. Health Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination.

Known Allergies:	**Height:**	**Weight:**
Medical History and Diagnoses:		
Physical or Sensory Limitations:		
Cognitive or Behavioral Status:		
Nursing/Treatment/Therapy Service Requirements:		
Special Precautions:	**Elopement Risk:** Yes: ☐ No: ☐	

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Section 1. Health Assessment (continued)

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination.

A. To what extent does the individual need supervision or assistance with the following?

	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care
Key	Staff does not assist at all	Staff provide cueing or prompting, but resident completes the action	Staff provide physical assistance with the resident's participation	Staff completes the action for the resident

Indicate by a checkmark (✓) in the appropriate column below.

ACTITIVIES OF DAILY LIVING:	I	S	A	T
Ambulation				
Bathing				
Dressing				
Eating				
Self-Care (grooming)				
Toileting				
Transferring				

B. Special Diet Instructions:

Regular ☐ **Calorie Controlled** ☐ **No Added Salt** ☐ **Low Fat/Low Cholesterol** ☐

Other (specify, including consistency changes such as puree): _____

_____

_____

C. Does the individual have any of the following conditions/requirements?

STATUS	YES	NO
A communicable disease, which could be transmitted to other residents or staff?		
Bedridden?		
Any stage 2, 3, or 4 pressure sores?		
Pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.)		
Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing, or psychiatric facility? Yes ☐ No ☐

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB: 06/01/1933
Authorized Representative (if applicable):	

Section 2. Self-Care and General Oversight Assessment - Medications

****A. Attach a listing of all currently prescribed medications, including dosage, directions for use, and route.**

B. Does the individual need help with taking his or her medications (meds)? Yes ☐ No ☐
If YES, place a checkmark (✓) in front of the appropriate box below:

☐ **Needs Assistance With Self-Administration**

- ❖ This allows unlicensed staff to assist with nasal, ophthalmic, oral, otic, and topical medications.

☐ **Needs Medication Administration**

- ❖ Not all assisted living facilities have licensed staff to perform this service.

☐ **Able To Self-Administer Medications**

- ❖ Resident does not need staff assistance

C. Additional Comments/Observations (use additional pages, if necessary): _____

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION.

Name of Examiner (please print):	
Medical License Number:	
Title of Examiner (check one): ☐ **MD** ☐ **DO** ☐ **APRN** ☐ **PA**	
Telephone Number:	
Address of Examiner:	
Signature of Examiner:	**Date of Examination:**