



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:	, 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: <input type="checkbox"/> No: <input type="checkbox"/>	

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?

Key	I = Independent Staff does not assist at all	S = Needs Supervision Staff provide cueing or prompting, but resident completes the action	A = Needs Assistance Staff provide physical assistance with the resident's participation	T = Total Care Staff completes the action for the resident
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Indicate by a checkmark (✓) in the appropriate column below.

ACTIVITIES 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): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Telephone Number:	
Address of Examiner:	
Signature of Examiner:	Date of Examination: