[](http://ahcaportal/multimediadesign/Official%20Logos/AHCA%20Official%20Logo%202014-Black.jpg)

**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: | | Telephone Number: | |
| Street Address: | | Fax Number: | |
| City: | County: | | Zip: |
| Contact Person: | | | |

|  |
| --- |
| **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. |

1. **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 |

**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** |  |  |  |  |

1. **Special Diet Instructions:**

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

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

1. **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?** |  |  |

1. **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: |
| Authorized Representative (if applicable): | |

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

1. **Attach a listing of all currently prescribed medications, including dosage, directions for use, and route.**
2. **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 |  |

1. **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:** |