

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-Aadmission <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 _____			
STATUS OF THE FOLLOWING:			
AMBULATING	BATHING	DRESSING	EATING
<input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help <input type="checkbox"/> Bedridden	<input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	<input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	<input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Tube feeding
GROOMING	SKIN INTEGRITY	TOILETING	TRANSFERRING
<input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	<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 _____	<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	<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 Type _____	<input type="checkbox"/> Requires physical restraints 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.

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 OR PHYSICIAN, PA, OR NP:		DATE:	
PRINTED NAME OF PHYSICIAN, PA OR NP		GEORGIA LICENSE#	
ADDRESS OF PHYSICIAN, PA, OR NP			
CITY		STATE	ZIP CODE
PLEASE RETURN COMPLETED FORM TO:			
CONTACT PERSON	FACILITY NAME		
Ann Cowan	Corinth Road Personal Care Home		
ADDRESS	PHONE:		
1141 Corinth Rd	770) 254-8734		
CITY	STATE	ZIP CODE	
Newnan	Ga	30263	