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

NAME OF PATIENT				DOB		HEIGHT					
PRESENT ADDRESS						WEIGHT					
CITY		STATE	ZIP	TELEPI	HONE						
REASON FOR EVALUATION:         Pre-Admission       Annual         Pre-Admission       Annual											
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:	Regular [	No added ta	ble salt 🗌 No	concentrated	sweets						
Other 8. STATUS OF THE FOLLOWING:											
AMBULATING Independent Needs supervision Needs assistance Needs total help Bedridden	BATHING Independent Needs super Needs assist Needs total h	vision ance	DRESSING Independent Needs super Needs assist Needs total h	vision ance		upervision ssistance					
GROOMING Independent Needs supervision Needs assistance Needs total help	SKIN INTEGRITY No pressure Stage one Stage two Stage three Stage four Location	sores	TOILETING Independent Needs super Hygiene assi Adult briefs Catheter care Ostomy	vision stance	Needs a	-					
RESTRAINTS Requires no restraints	Requires chem Type			Requires ph	iysical restrai	nts					
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	DIRECTION	NS FOR USE		ROUTE	TE NEEDS HELP WITH ADMINISTRATION YES NO					
							<u> </u>				
	MEDICAL CEF	RTIFICATION SIGN	ATURE REQUI	RED:							
Assisted living facilities/perso	nal care home	es ARE NOT pe	rmitted unde	r the la	<i>w</i> to provi	ide medica	l, 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:							
				B/(IL)							
PRINTED NAME OF PHYSICIAN, PA OR NP					<b>GEORGIA LICENSE #</b>						
ADDRESS OF PHYSICIAN, PA OR NI	P										
-											
CITY			STATE	ZIP (	CODE						
	-		ETED FORM	10:							
CONTACT PERSON	FACILI	TY NAME									
ADDRESS			PHONE:								
CITY			STATE		ZIP CODE						
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