**Section 295.APPENDIX A Physician's Assessment Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Resident Name: |  | Resident Representative, If any: |  |
| Birth Date: |  | Telephone: |  |
| Telephone: |  | Street Address: |  |
| Street Address |  | City/State/Zip: |  |
| City/State/Zip |  |  |
|  |  |
|  |  |
|  |  |
| Other Emergency Contact Person: |  |
| Complete Address: |  |
| Telephone Number: |  |
|  |  |
|  |  |
|  |  |
| **Purpose of Assessment:** |  |
|  |  |
| Prior to Admission | Annual | Significant Change in Condition |
| **ESTABLISHMENT** |
| Name: |  |
| Street Address: |  |
| City/State/Zip: |  | Telephone: |  |
| The Assisted Living and Shared Housing Act requires every resident, prior to admission, annually and upon identification of significant change in condition, to receive a comprehensive physician's assessment. The assessment must include an evaluation of the person's physical, cognitive, and psychosocial condition.  |
| The Act prohibits persons having certain conditions or limitations and requiring certain types of care from residing in an establishment. A list of these conditions, limitations, and types of care appears in **Part III** of this form.  |
| **Part I – I certify that the following have been completed:**  |
|  |  |
| a physical, psychosocial, and cognitive assessment;  |
| written instructions for any needed home health services, including periodic nutritional and skin integrity assessments; and |
| instructions, as appropriate, contained in **Part II** of this form. |
| I further certify that in my professional judgement the person for whom this certification is being completed meets the conditions, limitations, and care requirements specified in the Assisted Living and Shared Housing Act and outlined in **Part III** of this form. |
| Signature:  |  |
| **Physician Name:** |  |
| (typed or printed) |
| **Physician ID Number:** |  |
| **Part II – Personal Services Needs:** Based on my assessment, the resident's condition warrants assistance with the following personal services: (note any specific needs and instruction)  |
| **Activity of Daily****Living (ADL)** | **NO** |  | **YES** |  | **EXPLANATION** |
| Eating |  |  |  |  |  |
|  |
| Does resident have any special dietary needs? |  |  |  |  |  |
|  |
| Dressing |  |  |  |  |  |
|  |
| Toileting |  |  |  |  |  |
|  |
| Transferring |  |  |  |  |  |
|  |
| Bathing |  |  |  |  |  |
|  |
| Personal Hygiene |  |  |  |  |  |
|  |
| Can resident administer his/her own medication? |  |  |  |  |  |
|  |
| Does resident require supervision when taking medications? |  |  |  |  |  |
|  |
| Does resident require establishment personnel to administer medication? |  |  |  |  |  |
|  |
| **Part III – Residency Conditions, Care and Limitations** |
| **MUST**  |
| - | be an adult |
| - | pose no serious threat to anyone (including self) |
| - | be able to communicate needs |
| - | not have a severe mental illness |
| **NOT NEED**  |
| - | total assistance with 2 or more ADLs\* |
| - | assistance from more than 1 paid caregiver for any ADL\* |
| - | more than minimal assistance to move to safe area in case of emergency\* |
| - | 5 or more skilled nursing visits per week for conditions other than treatment of stage 3 or stage 4 decubitus ulcers (for a period not to exceed 3 consecutive weeks) |
| **NOT NEED (unless self-administered or administered by a qualified licensed health care professional)**  |
| - | intravenous and/or gastrostomy feeding therapies |
| - | insertion, sterile irrigation, and replacement of catheter, except for routine maintenance\* |
| - | sterile wound care |
| - | sliding scale insulin administration and injections |
| - | treatment of stage 3 or stage 4 decubitus ulcers or exfoliative dermatitis |
|  |  |
| \* | Except for quadriplegic, paraplegic, or individuals with neuro-muscular disease |