

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ Date of Exam: _____

Facility Name: _____ Date of Birth: _____ Sex: _____

Present Home Address: _____
Street City State Zip

Reason for evaluation: Pre-Admission 12 month Acute change in condition Other: _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse: _____ Resp: _____ T: _____ Height: _____ ft _____ in. Weight: _____

Primary Diagnosis(s): _____

Secondary Diagnosis(s): _____

Allergies: None or list Known Allergies: _____

Diet: Regular No Added Salt Limited Carbohydrate Other: _____

Immunizations: Influenza (Date _____) Pneumococcal Vaccine (Date _____)

TB SCREENING (performed within 30 days prior to initial admission unless medically contraindicated)

Test is contraindicated Test: TST1 TST2 TB Blood Test (Type) _____ Date _____ Result _____

TST1: Date placed _____ Date Read _____ mm _____ TST2: Date placed _____ Date Read _____ mm _____

Based on my findings and on my knowledge of this patient, I find that the patient _____ IS _____ IS NOT exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes No If no, is incontinence managed? Yes No
Bowel: Yes No If no, is incontinence managed? Yes No

If no, recommendations for management: _____

LABORATORY SERVICES: None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

Patient/Resident Name: _____

Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No Yes (describe): _____

Dependent on Medical Equipment: No Yes (describe): _____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent Intermittent Continual
2. Transfer: Independent Intermittent Continual
3. Feeding: Independent Intermittent Continual
4. Manage Medical Equipment: Manages Independently Cannot Manage Independently

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None or if yes, describe _____

Therapies: None Yes (specify): Physical Therapy Speech Therapy Occupational Therapy

Home Care: None Yes (specify): _____ Other (Specify): _____

Is Palliative Care Appropriate/Recommended: No If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? No Yes

If yes, do you recommended testing be performed? No If yes, referral to: _____

If testing has already been performed, date/place of testing if known: _____

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? No Yes

Has the patient ever been hospitalized for a mental health condition? No Yes

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
 No Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- Correctly read the label on a medication container
- Correctly follow instructions as the route, time dosage and frequency
- Correctly ingest, inject or apply the medication
- Measure or prepare medications, including mixing, shaking and filling syringes
- Open the container
- Safely store the medication
- Correctly interpret the label

Resident Name: _____ Date: _____

PRN Medications (check applicable)

___ Tylenol: 325 mg-2 tabs PO q 4 hr prn pain/elevated temp

___ Robitussin: 10cc PO q4h prn cough

___ Maalox: 30cc PO q4h prn indigestion

___ MOM: 30cc PO qd prn constipation

___ Able to request PRNs (not applicable for Mary Regina)

Medical Equipment (check applicable)

___ U-rail for positioning ___ Oxygen ___ Concentrator ___ Tank
(O2 Order) _____

___ Walker

___ Wheelchair

___ CPAP

___ Shower Chair

___ Elevated Toilet Seat

___ BI-PAP

___ Call Pendant

___ Cane

___ Electric Wheelchair/Scooter

___ Electric Blanket (auto shut-off only) ___ May use mini Lift (if needed)

___ Hospital bed with ½ side rail

___ Humidifier (auto shut-off only)

Miscellaneous Resident Information (check applicable)

___ May receive flu vaccine annually

___ May be served alcoholic beverages at activities with a two (2) 4 oz. drink maximum

___ May participate in activities and exercise program

___ May have meal trays in room without staff supervision

PMD Signature: _____ Date: _____