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:
☐ Pre-Admission ☐ Annual ☐ Possible change in patient's condition ☐ 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: ☐ Regular ☐ No added table salt ☐ No concentrated sweets
☐ Other_____

8. STATUS OF THE FOLLOWING:

AMBULATING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help
☐ Bedridden

BATHING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

DRESSING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

EATING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Tube feeding

GROOMING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

SKIN INTEGRITY
☐ No pressure sores
☐ Stage one
☐ Stage two
☐ Stage three
☐ Stage four
Location _____

TOILETING
☐ Independent
☐ Needs supervision
☐ Hygiene assistance
☐ Adult briefs
☐ Catheter care assistance
☐ Ostomy

TRANSFERRING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

RESTRAINTS
☐ Requires no restraints ☐ Requires chemical restraints Type_____ ☐ 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.

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION YES	NO

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 OF 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
ADDRESS	PHONE:
CITY / STATE / ZIP CODE	

The Villas at Canterfield

Medication List

Resident Name: _____

Drug Name/Dosage	Directions	Qty	Refills	Diagnosis

1. Unless otherwise specified, with your signature below, the pharmacy will assign 11 refills for non-controlled drugs
2. Qty and Refills must be filled in for each medication order for controlled drugs
3. A diagnosis is required for each medication order

Physician Name: _____

Physician Signature: _____

Date: _____

PHYSICIAN ORDERS FOR CARE IN THE EVENT THE RESIDENT HAS NO PULSE AND IS NOT BREATHING.

This is a Physician Order guided by the patient's medical condition and based upon personal preferences verbalized to the Physician, and/or Medical POA and/or expressed in a written Advance Directive.

Patient's Name (Print)_____
(First) (Middle) (Last)

Last four digits of SSN:_____ **Date of Birth** _____

Gender: Male ☐ Female ☐

In the event that the above Resident_____
does NOT have a pulse and is NOT breathing, the following Directive should be followed:

☐ **Attempt Cardiopulmonary Resuscitation/CPR.**

☐ **Allow Natural Death AND Do Not Attempt Cardiopulmonary Resuscitation.**

Physician's Printed Name License No. State	Physician's Signature		Date
Patient's Printed Name	Patient's Signature	Date	Phone
Patient Authorized Representative's Printed Name (if applicable)	Representative's Signature (if applicable)	Date	Phone