Rose's Place

The "Bed'n'Breakfast" of Senior Assisted Living

Health Care Practitioner's Assessment- Cover Page

Dear Health Care Practioner:

Rose's Place Incorporated is a Senior Assisted Living Facility that provides services that range for moderate assistance to full care for seniors. Our facilities provide full clinical services for our residents.

The attached form is required by the State of Maryland for all assisted living applicants. All questions must be answered in detail because the answers that you provide are used to determine the level of care your patient requires at our facility. It is essential that we determine the correct level of care so we are able to have a clear picture of the services he or she will need at our facility.

If you have any questions regarding our facility, our services, or these forms, please feel free to call our Assisted Living Manger, Maya Garrett, at 301-802-2649 or email maya@rosesplaceseniorалf.com and she will be happy to assist you.

Please give the original copy to the potential resident's family and fax us a copy to 240-638-9119.

Thank you for your assistance. Please print all information.

Date_____

Applicant's Name_____

Date of Birth _____

Social Security Number _____

Address _____

Telephone _____

Practitioner's Name _____

Practioner's Address _____

Practioner's Phone _____ Fax _____

Serving 2 locations in Maryland: Bowie and Upper Marlboro
301-499-4169- office
info@rosesplaceseniorалf.com
www.rosesplaceseniorалf.com

Resident Name _____ Date Completed _____

Date of Birth _____

Health Care Practitioner Physical Assessment Form

This form is to be completed by a primary physician, certified nurse practitioner, registered nurse, certified nurse-midwife or physician assistant. Questions noted with an asterisk are "triggers" for awake overnight staff.

Please note the following before filling out this form: Under Maryland regulations an assisted living program may not provide services to a resident who, at the time of initial admission, as established by the initial assessment, requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; or (6) Treatment for a disease or condition that requires more than contact isolation. An exception to the conditions listed above is provided for residents who are under the care of a licensed general hospice program.

1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)?

(Check one) ☐ Yes ☐ No If "No," then indicate the communicable disease: _____

Which tests were done to verify the resident is free from active TB?

PPD Date: _____ Result:_____mm

Chest X-Ray (if PPD positive or unable to administer a PPD) Date: _____ Result_____

Resident Name _____ Date Completed _____

Date of Birth _____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

(a) Substance: OTC, non-prescription medication abuse or misuse
1. Recent (within the last 6 months) ☐ Yes ☐ No
2. History ☐ Yes ☐ No

(b) Abuse or misuse of prescription medication or herbal supplements
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(c) History of non-compliance with prescribed medication
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(d) Describe misuse or abuse: _____
_____

6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): ☐ orthostatic hypotension ☐ osteoporosis ☐ gait problem ☐ impaired balance ☐ confusion ☐ Parkinsonism ☐ foot deformity ☐ pain ☐ assistive devices ☐ other (explain)

_____

7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders. _____

_____

8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing: Left ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Right ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid

(b) Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind (check all that apply) - ☐ R ☐ L

(c) Temperature Sensitivity: ☐ Normal ☐ Decreased sensation to: ☐ Heat ☐ Cold

9. Current Nutritional Status. Height _____inches Weight _____lbs.

(a) Any weight change (gain or loss) in the past 6 months? ☐ Yes ☐ No

(b) How much weight change? _____lbs. in the past _____ months (check one) ☐ Gain ☐ Loss

(c) Monitoring necessary? (Check one.) ☐ Yes ☐ No

If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(d) Is there evidence of malnutrition or risk for undernutrition? ☐ Yes ☐ No

(e)* Is there evidence of dehydration or a risk for dehydration? ☐ Yes ☐ No

(f) Monitoring of nutrition or hydration status necessary? ☐ Yes ☐ No

If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(g) Does the resident have medical or dental conditions affecting: (Check all that apply)
☐ Chewing ☐ Swallowing ☐ Eating ☐ Pocketing food ☐ Tube feeding

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted): _____
_____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids): _____
_____

(j) Is there a need for assistive devices with eating (If yes, check all that apply): ☐ Yes ☐ No
☐ Weighted spoon or built up fork ☐ Plate guard ☐ Special cup/glass

(k) Monitoring necessary? (Check one.) ☐ Yes ☐ No

If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur:
_____

Resident Name _____ Date Completed _____

Date of Birth _____

10.* Cognitive/Behavioral Status.

(a)* Is there evidence of dementia? (Check one.) ☐ Yes ☐ No

(b) Has the resident undergone an evaluation for dementia? ☐ Yes ☐ No

(c)* Diagnosis (cause(s) of dementia): ☐ Alzheimer's Disease ☐ Multi-infarct/Vascular ☐ Parkinson's Disease ☐ Other

(d) Mini-Mental Status Exam (if tested) Date _____ Score _____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10(e)	A	B*	C*	D*	Comments
Cognition					
I. Disorientation	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
II. Impaired recall (recent/distant events)	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
III. Impaired judgment	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
IV. Hallucinations	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
V. Delusions	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Communication					
VI. Receptive/expressive aphasia	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Mood and Emotions					
VII. Anxiety	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
VIII. Depression	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Behaviors					
IX. Unsafe behaviors	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
X. Dangerous to self or others	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
XI. Agitation (Describe behaviors in comments section)	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	

10(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

☐ (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment).

☐ (b) Probably can make limited decisions that require simple understanding.

☐ (c) Probably can express agreement with decisions proposed by someone else.

☐ (d) Cannot effectively participate in any kind of health care decision-making.

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

☐ (a) Independently without assistance

☐ (b) Can do so with physical assistance, reminders, or supervision only

☐ (c) Need to have medications administered by someone else

_____ _____

Print Name Date

_____

Signature of Health Care Practitioner

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited).	12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication.	12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections.	12(d) Related testing or monitoring. Include frequency & any instructions to notify physician.

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

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Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

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Prescriber's Signature _____ Date _____

Office Address _____ Phone _____